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TITLE 23

PUBLIC UTILITIES AND REGULATED INDUSTRIES

(CHAPTERS 1-29 IN VOLUME 22; CHAPTERS 30-59 IN VOLUME 23A; CHAPTERS 60-73 IN VOLUME 23B; CHAPTERS 88-115 IN VOLUME 24B)

SUBTITLE 3. INSURANCE

CHAPTER.

SUBTITLE 3. INSURANCE

CHAPTER 74

FRATERNAL BENEFIT SOCIETIES

SUBCHAPTER.

Subchapter 1 — Structure and Purpose

23-74-101. Fraternal benefit society defined.

RESEARCH REFERENCES

Ark. L. Notes. Sampson, Nonprofit Risk; Nonprofit Insurance, 2008 Ark. L. Notes 83.

Subchapter 5 — Financial

SECTION.

23-74-502. Funds.

(a) All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(c)(1) Pursuant to resolution of its supreme governing body, a society may establish and operate one (1) or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts as provided in § 23-81-401 et seq.

(2) To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may:

(A) Adopt special procedures for the conduct of the business and affairs of a separate account;

(B) For persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and

(C) Issue contracts on a variable basis to which § 23-74-404(b) and (d) shall not apply.

History. Acts 1989, No. 881, § 1.

Publisher's Notes. This section is being set out to reflect a correction in the subdivision (c)(2)(C) designation.

Subchapter 7 — Miscellaneous

SECTION.

23-74-703. Penalties.

Any person who:

(1) Willfully makes a false or fraudulent statement:

(A) In or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society upon conviction shall be guilty of a Class A misdemeanor; or

(B) In any verified report or declaration under oath required or authorized by this chapter or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for that purpose of procuring payment of a benefit named in the certificate shall be guilty of a Class C misdemeanor;

(2) Solicits membership for or in any manner assists in procuring membership in any society not licensed to do business in this state shall

be guilty of a violation and upon conviction shall be fined not less than fifty dollars ($50.00) nor more than two hundred dollars ($200); or

(3) Is guilty of a willful violation of or neglect or refusal to comply with this chapter for which a penalty is not otherwise prescribed shall be guilty of a violation and upon conviction shall be subject to a fine not exceeding one thousand dollars ($1,000).

History. Acts 1989, No. 881, § 1; 2005, No. 1994, § 356.

CHAPTER 75

HOSPITAL AND MEDICAL SERVICE CORPORATIONS

23-75-101. Definition.

RESEARCH REFERENCES

Ark. L. Notes. Sampson, Nonprofit Risk; Nonprofit Insurance, 2008 Ark. L. Notes 83.

23-75-102. Applicability of other laws.

The corporations described in § 23-75-101 are subject to the following chapters and provisions of this code, to the extent applicable and not in conflict with the express provisions of this chapter:

(1) Sections 23-60-101 — 23-60-108 and 23-60-110, referring to scope of code;

(2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., referring to the Insurance Commissioner;

(3) Sections 23-63-102 — 23-63-104, 23-63-201 — 23-63-216, and 23-63-301 — 23-63-304, referring to registration of registered agents for service of process;

(4) Section 23-63-901 et seq., referring to administration of deposits;

(5) Section 23-63-1501 et seq., referring to risk-based capital;

(6) Section 23-64-101 et seq., referring to insurance producers, agents, brokers, and adjusters;

(7) Section 23-66-201 et seq. and §§ 23-66-301 — 23-66-306, 23-66-308 — 23-66-311, 23-66-313, and 23-66-314, referring to trade practices and frauds;

(8) Section 23-63-601 et seq. and §§ 23-84-101 — 23-84-111, referring to assets and liabilities;

(9) Section 23-68-101 et seq., referring to rehabilitation and liquidation;

(10) Section 23-69-142, referring to mergers and acquisitions;

(11) Sections 23-85-101 — 23-85-131, referring to accident and health insurance policies;

(12) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108, and 23-86-109, referring to group and blanket accident and health insurance;

(13) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, referring to insurance contracts;

(14) Section 23-69-134, referring to home office and records; penalty for unlawful removal of records; and

(15) Section 23-69-156, referring to extinguishment of unused corporate charters.

History. Acts 1959, No. 148, § 690; 1971, No. 127, § 2; 1977, No. 789, § 8; 1981, No. 809, §§ 18-20; 1983, No. 522, §§ 37, 38; A.S.A. 1947, § 66-4920; Acts 2001, No. 580, § 21; 2001, No. 1454, § 2; 2001, No. 1604, § 75; 2011, No. 760, § 12.

Amendments. The 2011 amendment substituted "laws" for "provisions" in the section head; substituted "described in § 23-75-101 are" for "shall also be" in the introductory language; inserted present (5) and (10) and redesignated the remaining subdivisions accordingly; substituted "and §§ 23-66-301" for "23-66-301" in (7); and substituted "§§ 23-84-101" for "23-84-101" in (8).

23-75-106. Incorporation — Amendments to articles or bylaws.

(a) Any corporation shall hereafter be organized under the laws of this state relating to private corporations not for pecuniary profit, insofar as the laws are not inconsistent with this chapter.

(b)(1) Upon adoption of an amendment to its articles of incorporation or bylaws, the corporation shall make in duplicate under its corporate seal a certificate setting forth the amendment and the date and manner of its adoption.

(2) The certificate shall be:

(A) Executed by the corporation's president or vice president and secretary or assistant secretary; and

(B) Acknowledged before an officer authorized by law to take acknowledgments of deeds.

(3) The corporation shall deliver to the Insurance Commissioner:

(A) A duplicate original of the certificate; and

(B)(i) The filing fee that is:

(a) Specified in § 23-61-401; or

(b) Established by rule of the commissioner.

(ii) The filing fee is not refundable.

(4) If the commissioner finds that the certificate and the amendment comply with the law, the commissioner shall:

(A) Endorse his or her approval upon each of the duplicate originals;

(B) Place one (1) set on file in his or her office; and

(C) Return the remaining set to the corporation for its corporate records.

(5) The amendment shall be effective when the commissioner has endorsed his or her approval on the certificate.

(6) If the commissioner finds that the proposed amendment or certificate does not comply with the law, the commissioner shall:

(A) Not approve the certificate;

(B) Return the duplicate certificate to the corporation with his or her written statement of reasons for not approving the certificate; and

(C) Retain the filing fee.

History. Acts 1959, No. 148, § 673; A.S.A. 1947, § 66-4903; Acts 2009, No. 726, § 36.

Amendments. The 2009 amendment added (b), redesignated the remaining text accordingly, and made a minor stylistic change.

23-75-111. Subscription contracts.

(a)(1) All rates charged by the corporation to subscribers or classes of subscribers having contracts covered by §§ 23-85-101 — 23-85-131, and the form and content of all contracts between the corporation and its subscribers, classes of subscribers, or groups of subscribers, and the certificates issued by the corporation representing their subscribers' agreements shall be subject at all times to the prior approval of the Insurance Commissioner.

(2) Application for approval shall be made to the commissioner in such form and shall set forth such information as the commissioner may require.

(3) Rates shall not be excessive, inadequate, or unfairly discriminatory in relation to the services offered.

(4)(A) Upon the commissioner's review of an application at any time, if the applicant requests a hearing, the commissioner shall hold a hearing before issuing an order of disapproval. The applicant shall be given not less than ten (10) days' written notice of the hearing. The notice shall specify the matters to be considered at the hearing.

(B) If after the hearing provided by subdivision (a)(4)(A) of this section the commissioner finds that the application or a part thereof does not meet the requirements of this code, the commissioner shall issue an order specifying in what respects he or she finds that it fails. Notice thereof shall immediately be served on the applicant, either personally or by mail. Within thirty (30) days after the date of such a notice, the applicant may apply to the Pulaski County Circuit Court to show cause why the action of the commissioner should be set aside and the application approved.

(b)(1) In any hospital service corporation contract, any medical service corporation contract, or any hospital and medical service corporation contract, whether group or individual, that contains a provision whereby coverage of a dependent in a family group terminates at a specified age, there shall also be a provision that coverage of an unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so

incapacitated prior to the attainment of nineteen (19) years of age and who is chiefly dependent upon the contract holder or certificate holder for support and maintenance, shall not terminate, but coverage shall continue so long as the contract or certificate remains in force and so long as the dependent remains in such a condition.

(2) At the request and expense of the corporation, proof of the incapacity and dependency must be furnished to the corporation by the contract or certificate holder at least thirty-one (31) days before the child's attainment of the limiting age, and, subsequently, as may be required by the corporation, but not more frequently than annually, after the two-year period following the child's attainment of the limiting age.

(c)(1) Each contract shall plainly state the services to which the subscriber is entitled and those to which the subscriber is not entitled under the plan.

(2) As to benefits provided on a service, instead of cash indemnity basis, the contract shall constitute a direct obligation of the hospitals and physicians with which or with whom the corporation has contracted for hospital or medical services.

(3) A copy of the contract shall be delivered to the subscriber.

(d)(1) The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

(2) Each filing shall be on file for a waiting period of thirty (30) days before it becomes effective. The period may be extended by the commissioner for an additional period not to exceed thirty (30) days if the commissioner gives written notice within the waiting period to the insurer which made the filing that the commissioner needs such additional time for the consideration of the filing.

(3) Upon written application by the insurer, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof.

(4) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

History. Acts 1959, No. 148, § 678; 1969, No. 263, § 5; 1971, No. 127, § 1; 1975, No. 404, § 4; 1975, No. 642, § 2; 1975, No. 649, § 4, 8; 1979, No. 906, § 1; 1983, No. 522, § 49; A.S.A. 1947, § 66-4908; Acts 1997, No. 208, § 25; 2005, No. 1962, § 108.

CHAPTER 76

HEALTH MAINTENANCE ORGANIZATIONS

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2007, No. 429, § 3: Mar. 22, 2007. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the failure of state law to permit a waiver of admission requirements based upon evidence of a foreign insurer's prior successful operations before licensure and failure to permit health maintenance organizations to be governed by the Insurance Holding Company Regulatory Act hampers the ability of the state to attract additional health plans to base their operations in Arkansas, to promote economic growth, and to enhance consumer choices for health care coverage; that many states apply their insurance holding company laws to a foreign health maintenance organization doing business in the state if the health maintenance organization's state of domicile does not have substantially similar laws, thus potentially subjecting a health maintenance organization domiciled in Arkansas and licensed in other states to multiple holding company filings and inconsistent approval processes; and that this act is immediately necessary to attract insurers to the state by permitting the waiver of admission requirements when appropriate and the allowance of health maintenance organizations to elect to be subject to the Insurance Holding Company Regulatory Act and thus avoid duplicative and potentially inconsistent regulation in other states. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-76-101. Purpose.

RESEARCH REFERENCES

Ark. L. Notes. Sampson, Nonprofit Risk; Nonprofit Insurance, 2008 Ark. L. Notes 83.

23-76-102. Definitions.

As used in this chapter:

(1) "Commissioner" means the Insurance Commissioner;

(2) "Domestic corporation" means any corporation organized pursuant to the Arkansas Business Corporation Act, § 4-26-101 et seq., and the Arkansas Nonprofit Corporation Act, § 4-28-201 et seq.;

(3) "Enrollee" means an individual who has been enrolled in a health care plan;

(4) "Evidence of coverage" means any certificate, agreement, contract, identification card, or document issued to an enrollee setting out the coverage to which the enrollee is entitled;

(5) "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services through an individually underwritten or group master contract, and at least part of the arrangement consists of arranging for, or the provision of, health care services as distinguished from mere indemnification against the cost of the services on a prepaid basis through insurance or otherwise;

(6) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization, or services incident to the furnishing of care or hospitalization, as well as the furnishing to any person of all other services or goods for the purpose of preventing, alleviating, curing, or healing human illness or injury;

(7) "Health maintenance organization" means any person which undertakes to provide or arrange for one (1) or more health care plans;

(8) "Health professional" means physicians, dentists, optometrists, nurses, podiatrists, pharmacists, and other individuals engaged in the delivery of health services as are or may be designated under the Health Maintenance Organization Act of 1973 or any amendment thereto or regulation adopted thereunder;

(9) "Person" means any natural or artificial person, including, but not limited to, individuals, partnerships, associations, trusts, or corporations; and

(10) "Provider" means any person who is licensed in this state to furnish health care services as a health professional.

History. Acts 1975, No. 454, § 2; A.S.A. 1947, § 66-5202; Acts 1987, No. 456, § 21; 2005, No. 1697, § 20.

A.C.R.C. Notes. Acts 2005, No. 1697, § 1, provided: "Purpose. The General Assembly recognizes that a competitive market for insurance products is vital to Arkansans and that active competition in

the insurance marketplace produces the fairest and lowest rates over any given period of time. Furthermore, open and transparent regulation of the insurance industry as well as widespread dissemination of information concerning regulatory actions regarding insurance rates and information helpful to consumers in purchasing and utilizing insurance coverage will assist Arkansans in purchasing, maintaining, and utilizing wisely their insurance coverages. Therefore, the purpose of this act is to assist consumers by providing them the information and tools necessary to be an informed and educated consumer of insurance coverage."

23-76-103. Applicability of the Arkansas Insurance Code and laws concerning hospital and medical service corporations.

(a)(1) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of hospital and medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter.

(2) Subdivision (a)(1) of this section shall not apply to an insurer or hospital and medical service corporation licensed and regulated pursuant to the insurance laws or the hospital and medical service corporation laws of this state, except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) The provisions of this chapter, the Arkansas Insurance Code, and the law concerning hospital and medical service corporations, § 23-75-101 et seq., shall not be applicable to any nonprofit vision service plan corporation composed of at least fifty (50) participating licensed optometrists or ophthalmologists licensed by the State of Arkansas to provide vision care services on a prepaid basis, when each licensed optometrist or ophthalmologist is subject to the rules and regulations of the professional's respective state board, and when each participating licensed optometrist or ophthalmologist agrees to assume responsibility for completion of the provisions of the vision care services contracted for, so that no element of risk is incurred by any subscriber group or person.

(c) This chapter does not apply to health care sharing ministries as defined in § 23-60-104(b).

History. Acts 1975, No. 454, § 15; A.S.A. 1947, § 66-5215; Acts 1999, No. 881, § 10; 2001, No. 1605, § 1; 2013, No. 1163, § 2.

Amendments. The 2013 amendment added (c).

23-76-104. Arkansas Insurance Code sections applicable to health maintenance organizations.

(a) Except to the extent that the Insurance Commissioner determines that the nature of health maintenance organizations, health care plans, and evidences of coverage render such sections clearly inappropriate, the following sections are applicable to health maintenance organizations:

(1) Sections 23-60-101 — 23-60-108 and 23-60-110, referring to scope of the Arkansas Insurance Code;

(2) Section 23-61-101 et seq., § 23-61-201 et seq., and § 23-61-301 et seq., referring to the Insurance Commissioner;

(3) Sections 23-63-102 — 23-63-104, § 23-63-201 et seq., general provisions, and § 23-63-301 et seq., referring to service of process, a registered agent as process agent, serving legal process, and time to plead;

(4) Section 23-63-601 et seq., referring to assets and liabilities, and § 23-63-901 et seq., referring to administration of deposits;

(5) Section 23-63-1501 et seq., referring to risk-based capital requirements;

(6) Section 23-64-101 et seq., § 23-64-201 et seq., and § 23-64-501 et seq. referring to agents, brokers, solicitors, and adjusters;

(7) Section 23-66-201 et seq. and §§ 23-66-301 — 23-66-306 and 23-66-308 — 23-66-314, referring to trade practices and frauds;

(8) Section 23-68-101 et seq., referring to rehabilitation and liquidation;

(9) Section 23-69-134, referring to home office and records and the penalty for unlawful removal of records;

(10) Section 23-69-156, referring to extinguishing unused corporate charters;

(11) Sections 23-75-104, 23-75-105, and 23-75-116, referring to hospital and medical service corporations;

(12) Sections 23-79-101 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, referring to insurance contracts;

(13) Sections 23-85-101 — 23-85-132, 23-85-134, and 23-85-136, referring to individual accident and health insurance;

(14) Sections 23-86-101 — 23-86-104, 23-86-106, 23-86-108 — 23-86-111, 23-86-113 — 23-86-117, 23-86-119, 23-86-120, § 23-86-201 et seq., § 23-86-301 et seq., and § 23-86-401 et seq., referring to blanket and group accident and health insurance;

(15) Section 23-99-201 et seq., § 23-99-301 et seq., § 23-99-401 et seq., § 23-99-501 et seq., § 23-99-601 et seq., and § 23-99-701 et seq., referring to health care providers; and

(16) Section 23-64-515, referring to notice of termination of appointment.

(b)(1) A health maintenance organization domiciled or applying to be domiciled in this state may elect to be subject to the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., by:

(A) Written notice in its application at the time the health maintenance organization applies to be domiciled in Arkansas; or

(B) Providing thirty (30) days' prior written notice to the commissioner if the health maintenance organization was domiciled in Arkansas on March 22, 2007.

(2) An election under this subsection:

(A) Shall not be revoked;

(B) Requires that if a modification is required to be reported or filed under the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., the health maintenance organization shall comply with the provisions concerning notice of major modifications to the operation of the health maintenance organization under the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., instead of the provisions concerning notice of major modifications to the operation of the health maintenance organization under § 23-76-107(d); and

(C) Does not affect the duty of a health maintenance organization to make any other filing required under § 23-76-107(d) that is not required by the Insurance Holding Company Regulatory Act, § 23-63-501 et seq.

(c) If a health maintenance organization does not elect to be subject to the Insurance Holding Company Regulatory Act, § 23-63-501 et seq., it shall be subject to § 23-69-142 regarding mergers, consolidations, and acquisitions.

History. Acts 1975, No. 454, § 25; 1983, No. 624, § 2; A.S.A. 1947, § 66-5225; Acts 1999, No. 624, § 3; 2001, No. 1605, § 2; 2007, No. 429, § 2; 2011, No. 760, § 13; 2013, No. 355, § 11.

Amendments. The 2011 amendment inserted "and § 23-64-501 et seq." in (a)(6); and added (c).

The 2013 amendment added (a)(16).

23-76-105. Penalties — Enforcement.

(a) In lieu of suspension or revocation of a certificate of authority under § 23-76-123, the Insurance Commissioner may levy an administration penalty in an amount not less than two hundred fifty dollars ($250), nor more than two thousand five hundred dollars ($2,500), if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he or she calculates to be the damages suffered by the enrollees or other members of the public.

(b) Any person who willfully violates this chapter shall be guilty of a Class A misdemeanor.

(c)(1) If the commissioner shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violations.

(2) Proceedings under this subsection shall not be governed by formal procedural requirements and may be conducted in the manner the commissioner deems appropriate under the circumstances.

(d)(1) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

(2) Within thirty (30) days after service of the order of cease and desist, the respondent may request a hearing on the questions of whether acts or practices in violation of this chapter have occurred. The hearings shall be conducted pursuant to the provisions of §§ 23-61-303 — 23-61-307, and judicial review shall be available as provided in § 23-66-212.

(e) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the commissioner may institute a proceeding to obtain injunctive relief or, seeking other appropriate relief, in Pulaski County Circuit Court for actions of this nature.

History. Acts 1975, No. 454, § 24; A.S.A. 1947, § 66-5224; Acts 1987, No. 456, § 25; 2005, No. 1994, § 231; 2013, No. 1433, § 1.

Amendments. The 2013 amendment, in (c)(1), deleted "or the Director of the Department of Human Services" following "If the commissioner" and "or the director" following "the commissioner"; and in (c)(2), deleted "any" following "governed by," and substituted "in the manner the commissioner deems" for "in such manner as the commissioner or the director may deem."

23-76-107. Establishment.

(a)(1) Any person that meets the requirements of § 23-76-102(9) may apply to the Insurance Commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization.

(2) No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, nor solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this chapter.

(3) The corporation must have the express authority to operate a health maintenance organization contained in its articles of incorporation. Incorporation shall not be required of any entity that has been issued a certificate of authority prior to March 30, 1987.

(b)(1) Every health maintenance organization, as of July 9, 1975, shall submit an application for a certificate of authority under subsection (c) of this section within sixty (60) days of July 9, 1975.

(2) Each applicant may continue to operate until the commissioner acts upon the application.

(3) In the event that an application is denied under § 23-76-108, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) A copy of any contract made or to be made between any providers or persons listed in subdivision (c)(3) of this section and the applicant;

(5) A statement generally describing the health maintenance organization, its health care plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, that is to be issued to employers, unions, trustees, or other organizations;

(8)(A) Financial statements showing the applicant's assets, liabilities, and sources of financial support.

(B) If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter;

(9) A financial feasibility plan that includes:

(A) Detailed enrollment projections;

(B) The methodology for determining premium rates to be charged during the first twelve (12) months of operation certified by an actuary or other qualified person;

(C) A projection of balance sheets;

(D) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year; and

(E) A statement as to the source of working capital as well as any other sources of funds;

(10)(A) On and after January 1, 2003, a power of attorney executed by the applicant, if not domiciled in this state, and filed, along with a proper fee specified by the commissioner, with the commissioner's

office to register an Arkansas resident to serve as the true and lawful attorney of the applicant in and for this state upon whom may be served all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state.

(B) In the event no registered agent has been chosen, the commissioner may be served until the appointment of an Arkansas-registered agent for service of process has been entered upon the records of the commissioner;

(11) A statement or map reasonably describing the geographic areas to be served;

(12) A description of the complaint procedures to be utilized as required under § 23-76-116;

(13) A description of the procedures and programs to be implemented to meet the quality of health care requirements in § 23-76-108;

(14) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under § 23-76-110(b);

(15) A list of the names and addresses of all providers with which the health maintenance organization has agreements; and

(16) Such other information as the commissioner may require to make the determinations required in § 23-76-108.

(d)(1) A health maintenance organization shall file a notice describing any major modification of the operation set out in the information required by subsection (c) of this section unless otherwise provided for in this chapter. The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within sixty (60) days of filing, the modification shall be deemed approved.

(2) The commissioner shall promulgate rules and regulations exempting from the filing requirements of subdivision (c)(1) of this section those items the commissioner deems unnecessary.

History. Acts 1975, No. 454, § 3; A.S.A. 1947, § 66-5203; Acts 1987, No. 456, § 22; 1993, No. 901, § 35; 2001, No. 1605, § 3; 2013, No. 1433, § 2.

Amendments. The 2013 amendment deleted "(a)(2)" following "23-76-108" in (c)(13).

23-76-108. Issuance of certificate of authority.

(a) Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall determine whether the applicant furnishes or proposes to furnish adequate and accessible health care services for its health care plans subject to the requirements or rules of the State Insurance Department.

(b) The commissioner shall issue a certificate of authority to any person filing an application pursuant to § 23-76-107 within sixty (60) days of receipt of the application if the commissioner is satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) The health maintenance organization's proposed plan of operation meets the requirements of subsection (a) of this section;

(3) The health care plan will allow the health maintenance organization effectively to provide or arrange for the provision of basic health care services through insurance or otherwise on a prepaid basis, subject to reasonable requirements for copayments;

(4) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees;

(5) The health care plan's arrangements for health care services and the schedule of charges for use therewith are financially sound and reasonable;

(6) Any agreements with insurers, hospitals, medical service corporations, governmental entities, or any other organizations for insuring the payment of the cost of health care services or the provision for automatic applicability of alternative coverage in the event of discontinuance of the plan are reasonable and adequate;

(7) Agreements with providers for the provision of health care services are reasonable and adequate;

(8) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to § 23-76-110;

(9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to § 23-76-107 or by independent investigation is contrary to the public interest;

(10) Any deposit of cash or securities, in an amount determined to be appropriate by the commissioner pursuant to § 23-76-118, is sufficient to guarantee that the obligations to provide the promised benefits will be performed; and

(11) The applicant has paid-in capital in an amount not less than one hundred thousand dollars ($100,000) and additional working capital or surplus funds in an amount deemed by the commissioner to be adequate in relation to the proposed plan of operation.

(c) A certificate of authority shall be denied by the commissioner only after compliance with the requirements of § 23-76-126.

History. Acts 1975, No. 454, § 4; 1979, No. 942, § 16; A.S.A. 1947, § 66-5204; Acts 1987, No. 456, § 23; 2013, No. 1433, § 3.

Amendments. The 2013 amendment redesignated and rewrote former (a)(1) as present (a); deleted (a)(2) and (a)(3); substituted "receipt of the application if the commissioner is satisfied that" for "receipt of the certificate from the director, when the commissioner is satisfied that the following conditions are met" in the introductory language of (b); in (b)(2), deleted "director certifies in accordance with subsection (a) of this section that the," and substituted "subsection (a)" for "subdivision (a)(2)"; in (b)(3), substituted "will allow" for "constitutes an appropriate mechanism whereby," "effectively to" for "will effectively," and "subject to" for "through insurance or otherwise, except to the extent of," and inserted "through insurance or otherwise"; deleted (b)(10); redesignated former (b)(11) and (b)(12) as present (b)(10) and (b)(11); and inserted "by the commissioner" in (c).

23-76-110. Advisory board.

(a) The advisory board of any health maintenance organization shall include at least one (1) physician, one (1) dentist, one (1) pharmacist, one (1) nurse, one (1) consumer, and one (1) enrollee.

(b) The advisory board shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

(c) The advisory board shall not be deemed to be the governing body of the health maintenance organization licensed under this chapter.

History. Acts 1975, No. 454, § 6; A.S.A. 1947, § 66-5206; Acts 2005, No. 506, § 37.

23-76-113. Annual report and quarterly report.

(a) A health maintenance organization shall annually on or before March 1 file a report verified by at least two (2) principal officers with the Insurance Commissioner covering the preceding calendar year.

(b)(1) The report shall be on forms prescribed by the commissioner.

(2) For the report to be filed March 1, 2002, and annually thereafter, the annual report prescribed by the commissioner shall be the current edition, published by the National Association of Insurance Commissioners, of the "Annual Statement Blank For Health", that shall be prepared in accordance with the National Association of Insurance Commissioners' "Annual Statement Instructions For Health" and shall follow those accounting practices and procedures prescribed and published in the current edition of the National Association of Insurance Commissioners' "Accounting Practices and Procedures Manual".

(3) Each authorized health maintenance organization shall furnish all information as called for by the National Association of Insurance Commissioners' "Annual Statement Blank For Health". Further, it shall be verified by oath or affirmation of the health maintenance organization's president or vice president and secretary or actuary.

(4) The commissioner shall furnish to each domestic health maintenance organization two (2) copies of the forms on which the annual statement is to be made.

(5) The annual report shall include:

(A) An annual audited financial report certified by an independent certified public accountant;

(B) Any material changes in the information submitted pursuant to § 23-76-107(c);

(C) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(D) A summary of information compiled pursuant to § 23-76-108 in the form required by the commissioner; and

(E) Any other information on an annual, quarterly, or more frequent basis as the commissioner shall prescribe, relating to the performance of the health maintenance organization, that is necessary to enable the commissioner to carry out his or her duties under this chapter.

(c) Any health maintenance organization that fails to file the annual, quarterly, or any required financial or other report when due may be subject to a penalty of one hundred dollars ($100) for each day of delinquency in the commissioner's discretion, or unless the penalty is waived by the commissioner upon a showing of good cause by the organization.

(d)(1)(A) Beginning on and after January 1, 2000, each authorized health maintenance organization shall prepare and file with the commissioner a quarterly financial report on forms and at such times as shall be prescribed by the commissioner.

(B) For the reports to be filed January 1, 2002, and quarterly reports thereafter, the quarterly financial report shall be the current edition, published by the National Association of Insurance Commissioners, of the "Quarterly Statement Blank For Health", that shall be prepared in accordance with the National Association of Insurance Commissioners' "Quarterly Statement Instructions For Health" and shall follow those accounting procedures and practices prescribed by the National Association of Insurance Commissioners' "Accounting Practices And Procedures Manual".

(2) The quarterly statement shall be verified by the officers of the health maintenance organization as required by the current edition, published by the National Association of Insurance Commissioners, of the quarterly statement instructions as a companion to the reporting form prescribed by the commissioner.

History. Acts 1975, No. 454, § 9; A.S.A. 1947, § 66-5209; Acts 1989, No. 772, § 16; 1999, No. 301, § 2; 2001, No. 1605, §§ 9, 10; 2013, No. 1433, §§ 4, 5.

Amendments. The 2013 amendment, in (a), substituted "A" for "Every," and deleted "with a copy to the Director of the Department of Health" following "Insurance Commissioner"; and substituted "the form required by the commissioner" for "such form as required by the director" in (b)(5)(D).

23-76-116. Complaint system.

(a)(1) Every health maintenance organization shall establish and maintain a complaint system that has been approved by the Insurance Commissioner to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

(2) Each health maintenance organization shall submit to the commissioner an annual report in a form prescribed by the commissioner that shall include:

(A) A description of the procedures of the complaint system;

(B) The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed; and

(C) The number, amount, and disposition of malpractice claims settled during the year by the health maintenance organization.

(b)(1) The health maintenance organization shall maintain records of written complaints filed with it concerning issues and persons other than health care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require.

(2) Complaints involving other persons shall be referred to the persons with a copy to the commissioner.

(c) The commissioner may examine the complaint system, subject to the limitation concerning medical records of individuals set forth in § 23-76-122(c).

History. Acts 1975, No. 454, § 12; A.S.A. 1947, § 66-5212; Acts 2001, No. 1605, § 7; 2013, No. 1433, § 6.

Amendments. The 2013 amendment deleted "after consultation with the Director of the Department of Health" following "Insurance Commissioner" in (a)(1); in (a)(2), deleted "and the director" following "to the commissioner" and "after consultation with the director" following "by the commissioner"; redesignated former (b) as present (b)(1) and (b)(2); inserted "issues and person" in (b)(1); and deleted "or the director" following "The commissioner" in (c).

23-76-122. Examinations.

(a) The Insurance Commissioner may make an examination of the affairs of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than one (1) time every three (3) years.

(b) The commissioner may make an examination concerning the quality of health care services of any health maintenance organization as often as he or she deems it necessary for the protection of the interests of the people of this state but not less frequently than one (1) time every three (3) years.

(c)(1) Every health maintenance organization shall submit its books and records relating to the health care plan to the examinations and in every way facilitate them.

(2) For the purpose of examinations, the commissioner may administer oaths to and examine the officers and agents of the health maintenance organization.

(3) Medical records of individuals and records of physicians and hospitals providing services under a contract to the health maintenance organization shall be subject to the examination.

(d) The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner.

(e) In lieu of the examination, the commissioner may accept the report of an examination made by the insurance commissioner of another state or director of the department of health of another state.

(f)(1) Any examination under this section that is to commence within one (1) year prior to the date a health maintenance organization shall cease to provide health care services in this state, may be reduced in scope or waived in its entirety, upon application of the health maintenance organization and approval of the commissioner.

(2) The commissioner shall consider the following in determining whether a full or partial waiver may be granted:

(A) Claims payment history;

(B) Consumer complaint history;

(C) Financial condition; and

(D) Compliance with § 23-76-118.

(3) Any health maintenance organization requesting a waiver of an examination shall continue to comply with § 23-76-118 until such time as it is no longer providing health care services in this state.

History. Acts 1975, No. 454, § 18; A.S.A. 1947, § 66-5218; Acts 2001, No. 1605, § 8; 2013, No. 1433, § 7.

Amendments. The 2013 amendment substituted "commissioner" for "Director of the Department of Health" in (b); deleted "and the director" following "the commissioner" in (c)(2); deleted "or the director for whom the examination is being conducted" at the end of (d); in (e), deleted "or the director" following "the commissioner," and inserted "insurance" and "of another state"; and deleted "with the department" at the end of (f)(2)(B).

23-76-123. Suspension or revocation of certificate of authority.

(a) The Insurance Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if the commissioner finds that any of the following conditions exist:

(1) The health maintenance organization is operating in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 23-76-107, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of § 23-76-112;

(3) The health care plan does not provide or arrange for basic health care services;

(4) The health maintenance organization:

(A) Does not meet the requirements of § 23-76-108; or

(B) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under § 23-76-110;

(7) The health maintenance organization has failed to implement the complaint system required by § 23-76-116 in a manner to reasonably resolve valid complaints;

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has otherwise failed to substantially comply with this chapter.

(b) A certificate of authority shall be suspended or revoked only after compliance with the requirements of § 23-76-126.

(c) When the certificate of authority of a health maintenance organization is suspended, during the period of the suspension the health maintenance organization shall not:

(1) Enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees; and

(2) Engage in any advertising or solicitation whatsoever.

(d)(1) When the certificate of authority of a health maintenance organization is revoked, the organization shall:

(A) Proceed to wind up its affairs immediately following the effective date of the order of revocation;

(B) Conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization; and

(C) Engage in no further advertising or solicitation whatsoever.

(2) By written order, the commissioner may permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History. Acts 1975, No. 454, § 19; A.S.A. 1947, § 66-5219; Acts 2013, No. 1433, § 8.

Amendments. The 2013 amendment deleted "The Director of the Department of Health certifies to the commissioner that" in (a)(4); subdivided and redesignated former (a)(4)(A) as present (a)(4) and (a)(4)(A); and substituted "Is" for "The health maintenance organization is" in (a)(4)(B).

23-76-126. Administrative proceedings.

(a)(1) If the Insurance Commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall:

(A) Notify the health maintenance organization in writing of the grounds for suspension or revocation of the certificate of authority; and

(B) Schedule a hearing on the matter at least twenty (20) days after giving written notice of the hearing.

(2) After the hearing or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take appropriate action and mail written findings to the health maintenance organization.

(b)(1) The action of the commissioner may be appealed to the Pulaski County Circuit Court upon the record of the proceedings, hearing, and findings of the commissioner.

(2) The commissioner's decision shall be affirmed if it is supported by the preponderance of the evidence in the record.

(c) The Arkansas Administrative Procedure Act, § 25-15-201 et seq., applies to proceedings under this section to the extent it is not in conflict with this section.

History. Acts 1975, No. 454, § 22; 1979, No. 942, § 17; 1985, No. 804, § 18; A.S.A. 1947, § 66-5222; Acts 1987, No. 456, § 24; 2013, No. 1433, § 9.

Amendments. The 2013 amendment deleted former (a), (b)(2)(A) and (b)(2)(B); redesignated and rewrote former (b)(1), (b)(2)(C), (c) and (d) as present (a)(1), (a)(2), (b), and (c).

23-76-127. Fees.

A health maintenance organization subject to this chapter shall pay to the State Insurance Department Trust Fund as special revenues the following fees:

(1) For filing and reviewing all documents necessary for issuance of an original certificate of authority, one thousand dollars ($1,000);

(2) For issuance of the original certificate of authority, two hundred dollars ($200);

(3) For annual renewal of the certificate of authority, one hundred dollars ($100);

(4) For filing an annual statement, fifty dollars ($50.00); and

(5) For filing amendments to documents required under § 23-76-107, one hundred dollars ($100).

History. Acts 1975, No. 454, § 23; 1985, No. 804, § 13; A.S.A. 1947, § 66-5223; Acts 1987, No. 264, §§ 1, 2; 1993, No. 901, § 36; 2013, No. 1433, § 10.

Amendments. The 2013 amendment deleted "Disposition of revenues" in the section heading; deleted (a) and (b); deleted the subsection (c) designation; and substituted "A health" for "Every health" in the introductory language.

23-76-130. Insurance Commissioner's authority to contract.

(a) The Insurance Commissioner may contract with qualified persons to make recommendations concerning the adequacy, network adequacy, or accessibility of health care services under a health care plan furnished or proposed to be furnished by a health maintenance organization.

(b) The commissioner may accept all or part of the recommendations.

History. Acts 1975, No. 454, § 28; A.S.A. 1947, § 66-5228; Acts 2013, No. 1433, § 11.

Amendments. The 2013 amendment substituted "Insurance Commissioner's" for "Director of the Department of Health's" in the section heading; rewrote (a), which formerly read: "In carrying out his or her obligations under §§ 23-76-108(a)(2), 23-76-122(b), and 23-76-123(a), the Director of the Department of Health may contract with qualified persons to make recommendations concerning the determination required to be made by him or her"; and rewrote (b), which formerly read: "The recommendations may be accepted in full or in part by the director."

CHAPTER 77

AUTOMOBILE CLUBS OR ASSOCIATIONS

SECTION.

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-77-103. Penalty.

(a) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for an automobile club or association or offer any of the motor club services as defined in § 23-77-101, except in the manner provided in this chapter and under the rules and regulations promulgated by the Insurance Commissioner.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a Class A misdemeanor.

History. Acts 1955, No. 377, § 7; A.S.A. 1947, § 75-1607; Acts 2005, No. 1994, § 357.

23-77-107. Certificate of authority — Suspension and revocation.

(a) The Insurance Commissioner shall suspend or revoke the certificate of authority of an automobile club or association:

(1) If the action is required by any provision of this section or §§ 23-77-101, 23-77-106, or 23-77-108;

(2) If the automobile club or association no longer meets the requirements for the authority originally granted due to a deficiency in the deposit required by § 23-77-106(d)(1)(A) or the failure to maintain a deposit of securities or other assets acceptable to the commissioner in the amount prescribed by § 23-77-106(d)(1)(A); or

(3) If the automobile club or association is using such methods or practices in the conduct of its business as to render its further operation in Arkansas hazardous or injurious to the public.

(b) The commissioner shall give the automobile club or association at least ten (10) days' written notice in advance of any suspension or revocation under this section.

(c) The automobile club or association may request a hearing thereon within the ten (10) days.

History. Acts 1955, No. 377, § 12, as added by Acts 1981, No. 821, § 4; A.S.A. 1947, § 75-1605.1; Acts 2005, No. 506, § 38.

CHAPTER 78

BURIAL ASSOCIATIONS

23-78-104. Penalty.

(a) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for a burial association, or for participation in any plan, scheme, or device similar to burial associations, except in the manner provided by this chapter and the rules and regulations promulgated by the Burial Association Board.

(b) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of this section shall be guilty of a Class A misdemeanor.

History. Acts 1953, No. 91, § 16; A.S.A. 1947, § 66-1816; Acts 2005, No. 1802, § 1; 2005, No. 1994, § 358.

A.C.R.C. Notes. "Pursuant to § 1-2-207, this section is set out above as amended by Acts 2005, No. 1994. This

section was amended by Acts 2005, No. 1802 to read as follows: Penalty.

"(a)(1) It shall be unlawful for any person, firm, association, copartnership, corporation, company, or other organization to organize, operate, or in any way solicit members for a burial association, or for participation in any plan, scheme, or device similar to burial associations, except in the manner provided by this chapter and the rules and regulations promulgated by the Burial Association Board.

"(2) Any person, firm, association, copartnership, corporation, company, or other organization violating the provisions of subsection (a) of this section shall be guilty of a Class D felony.

"(3) In addition to a fine or imprisonment, or both, a person convicted of a violation of this subsection shall be ordered to pay restitution to persons aggrieved by the violation.

"(b)(1) Any officer, agent, employee, or other individual who collects proceeds or assessments from members of burial associations shall be guilty of a Class D felony if he or she:

"(A) Fails to deposit the collected amounts in the trust fund of the burial association; or

"(B) Fails or knowingly makes or allows to be made a false entry on the record of the burial association with:

"(i) Intent to deceive or defraud any member of the burial association; or

"(ii) Intent to conceal the true financial condition of the burial association from regulators.

"(2) Any officer, agent, employee, or other individual who diverts funds from a burial association for his or her personal use or to pay expenses of the contract funeral home not authorized by this subchapter shall be guilty of a Class D felony.

"(3) In addition to a fine or imprisonment, or both, a person convicted of a violation of this subsection shall be ordered to pay restitution to the Burial Association Board or to persons aggrieved by the violation."

23-78-107. Burial Association Board — Office and employees.

(a)(1) The Burial Association Board shall rent or otherwise acquire suitable quarters for an office and employ and fix the duties and the salaries of an executive secretary, two (2) auditors, and such other clerical assistance as may be necessary to carry out this chapter.

(2) The board may, if it deems advisable, require other employees to make a good and sufficient corporate bond to the board at the expense of the board in such amount as the board shall determine for the faithful performance of their duties.

(b) Legal counsel shall be furnished by the office of the Attorney General.

(c) There is established for the board the maximum number of employees necessary for the maintenance and operation of the board and the maximum rates of salaries for the employees. The board is authorized to make payment for salaries, services, and other purposes from the funds received by the board.

(d) The board is authorized to make reimbursement of the necessary and reasonable travel, board, and lodging expenses of the executive secretary and auditors incurred in the performance of their duties.

History. Acts 1953, No. 91, § 4; 1957, No. 403, §§ 1, 2; 1961, No. 84, § 1; 1965, No. 83, § 1; 1981, No. 360, § 1; 1983, No. 784, § 1; 1985, No. 679, § 2; A.S.A. 1947, §§ 66-1804 — 66-1804.2; Acts 2011, No. 875, § 1.

Amendments. The 2011 amendment deleted former (a)(2) and redesignated the following subdivision accordingly.

23-78-110. Certificate of authority.

(a) Applications for certificate of authority shall be on forms furnished by the Burial Association Board, and no burial association shall begin operation until the application shall have been approved and certificate of authority shall have been granted by the board.

(b) The following documents and information shall be filed with the application for a certificate of authority:

(1) Consent to service of process upon the secretary of the applicant;

(2) A copy of the proposed form of membership application, membership certificate, bylaws, and contracts for service, merchandise, supplies, and any other data requested by the board;

(3) References as to character, ability, and integrity of the organizers and of any funeral director or embalmer with whom the applicant proposes to contract;

(4) An application fee as determined by rule of the board; and

(5)(A) Proof of a deposit to the association's mortuary funds in an amount determined by rule of the board.

(B) The deposit required under subdivision (b)(5)(A) of this section shall not exceed ten thousand dollars ($10,000).

(c) If the board is satisfied that the applicant is qualified and meets the requirements of this chapter, the board shall issue to the applicant a certificate of authority.

History. Acts 1953, No. 91, § 8; A.S.A. 1947, § 66-1808; Acts 2007, No. 583, § 1; 2011, No. 875, § 2.

Amendments. The 2011 amendment added "for a certificate of authority" in the introductory language of (b); inserted (b)(4) and (b)(5); and deleted "upon receipt of the sum of five hundred dollars ($500)" at the end of (c).

23-78-111. Fees — Oath at payment.

(a)(1) In order to meet the expense of supervision and of carrying out the other provisions of this chapter, the Burial Association Board may set license fees for burial associations subject to its jurisdiction as set forth in § 23-78-109.

(2) The board shall collect the annual license fee from each burial association that is operating and in good standing on or before February 15 of the year in which the license fee is payable.

(b)(1) The fee shall be due and payable to the board not later than February 1 of each year, and upon payment of the fee, the board shall issue to each burial association a license that shall entitle the association to do business in the State of Arkansas during the calendar year for which the license is issued.

(2) If the license fee for any year is not paid within thirty (30) days from the date upon which it is due, the board may revoke and cancel the authorization of the delinquent burial association to transact business in the State of Arkansas.

(c) It shall be the duty of every burial association to certify under oath at the time of the payment of the license fee the true and correct

membership of the burial association on January 1 of the applicable year.

(d) If any officer or agent of any burial association knowingly makes any false statement with respect to the information required by this section to be furnished, he or she shall be guilty of a Class A misdemeanor.

(e) The board shall have and is given the power and authority to reduce or increase, temporarily or permanently, the fees set forth in subsection (a) of this section if the board deems such an action advisable.

History. Acts 1953, No. 91, § 14; 1973, No. 515, § 1; 1975, No. 380, § 1; 1979, No. 244, § 1; 1981, No. 494, § 2; 1983, No. 784, § 2; 1985, No. 480, § 1; A.S.A. 1947, § 66-1814; Acts 1989, No. 344, § 1; 1995, No. 485, § 1; 2005, No. 1994, § 457; 2009, No. 552, § 1; 2011, No. 875, § 3.

Amendments. The 2009 amendment deleted (a)(1)(B), redesignated the remaining text accordingly, and made a minor stylistic change.

The 2011 amendment substituted "on or before February 15" for "on January 1" in (a)(2).

23-78-114. False claim, promise, or representation of agent.

Any burial association official or agent or any representative of a burial association who for the purpose of inducing a member of one (1) association to change membership to another association shall make any false claim, promise, or representation not authorized in the bylaws of the association represented by him or her shall be guilty of a Class A misdemeanor.

History. Acts 1953, No. 91, § 18; A.S.A. 1947, § 66-1818; Acts 2005, No. 1994, § 359.

23-78-118. Books — False entries prohibited.

Any person or burial association official who knowingly makes or allows to be made any false entry on the books of the association with intent to deceive or defraud any member of the association or with intent to conceal the true condition of the association from the Burial Association Board or its agents or employees or any auditor authorized to examine the books of the association under the supervision of the board shall be guilty of a Class A misdemeanor.

History. Acts 1953, No. 91, § 19; A.S.A. 1947, § 66-1819; Acts 2005, No. 1994, § 360.

23-78-120. Semiannual reports.

(a)(1) Using forms provided by the Burial Association Board, each burial association or society licensed in this state shall file a semiannual report showing the actual financial condition of the burial association or society as of June 30 and December 31 of each year.

(2) The report shall include documents and information as required by rule of the board.

(b)(1)(A) The report required under this section is due as of June 30 and December 31 each year.

(B) A report is delinquent if:

(i) It is due as of June 30, and it is filed with the board after August 15 of the year it is due; or

(ii) It is due as of December 31, and it is filed with the board after February 15 of the year next following the year it is due.

(2) If a due date under subdivision (b)(1) of this section falls on a weekend or holiday, the report shall be due on the first business day following the weekend or holiday.

(3)(A) The board may grant an extension of time to submit a report for good cause.

(B) A burial association or society shall file a request for an extension to the board in writing before the due date of the report.

(4)(A) A report submitted to the board that omits required documents or information shall not be considered as filed with the board and will be returned to the burial association or society for corrections or completion.

(B) A report that omits required documents or information is delinquent if the submission of documents or information to complete the report:

(i) Causes a report that is due as of June 30 to be filed with the board after August 15 of the year it is due; or

(ii) Causes a report that is due as of December 31 to be filed with the board after February 15 of the year next following the year it is due.

(5) A burial association or society whose report is delinquent is subject to a financial penalty established by rule of the board.

(c) The board shall recover costs incurred in conducting audits and preparing the semiannual report from those associations which fail to file the report prior to the expiration of the deadline referred to in subsection (b) of this section. Costs to be recouped shall include:

(1) Round-trip mileage from the board's office to the association, at the rate then prevailing for other state employees engaged in travel;

(2) Per-diem expenses at the rate then prevailing for other state employees engaged in travel;

(3) Plus a two-hundred-fifty-dollar fee for preparing the report.

History. Acts 1953, No. 91, § 14; 1985, No. 480, § 2; A.S.A. 1947, § 66-1814; Acts 2011, No. 875, § 4.

Amendments. The 2011 amendment rewrote (a) and (b).

23-78-125. Revocation of certificate, license, charter, etc. — Appeal.

(a) Upon the revocation of any certificate of authority, charter, or other authority by the Burial Association Board under any of the

provisions of this chapter, the association or person whose certificate of authority, charter, license, or other authority has been revoked shall have the right of appeal from the action of the board revoking the certificate of authority, charter, or other authority to the circuit court of the county in which the burial association may be located.

(b) Appeals shall be made in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 1953, No. 91, § 21; 1981, No. 360, § 5; A.S.A. 1947, § 66-1821; Acts 2011, No. 875, § 5.

Amendments. The 2011 amendment deleted (c) through (e).

CHAPTER 79

INSURANCE POLICIES GENERALLY

SUBCHAPTER.

Subchapter 1 — General Provisions

SECTION.

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2005, No. 1995, § 3: Apr. 11, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that Act 1455 of 2003 was adopted by the General Assembly to assure freedom of choice for individuals receiving services from licensed audiologists and to assure equal payment or reimbursement to licensed audiologists; that despite Act 1455 of 2003 licensed audiologist have had difficulty obtaining payment or reimbursement; and that to protect the health of the public this act is immediately necessary. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2007, No. 684, § 10, provided: "Sections 1 through 9 of this act take effect January 1, 2008."

Acts 2013, No. 427, § 2: Mar. 15, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that only licensed dentists should be permitted to deny claims; that there are no standards in place governing denial of dental claims; and that this void endangers the health of Arkansans in need of dental services. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-79-101. Definitions.

As used in this section and §§ 23-79-102 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210:

(1) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers made a part thereof; and

(2) "Premium" is the consideration for insurance, by whatever name called. Any assessment, or any membership, policy, survey, inspection,

service, or similar fee or charge in consideration for a policy is deemed part of the premium.

History. Acts 1959, No. 148, §§ 269, 270; A.S.A. 1947, §§ 66-3202, 66-3203; Acts 2001, No. 1604, § 78; 2007, No. 496, § 15.

23-79-102. Scope.

Sections 23-79-101, 23-79-103 — 23-79-107, 23-79-109 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210 do not apply to:

(1) Reinsurance;

(2)(A) Policies or contracts not issued for delivery in this state nor delivered in this state, except:

(i) On subjects of insurance other than life or accident and health insurance, located or to be performed in this state; and

(ii) Pursuant to § 23-79-109(e).

(B) Subdivision (2)(A) of this section does not apply to group insurance certificates issued under group insurance policies carried out and delivered outside this state but covering a person that is a resident in this state;

(3) Wet marine and foreign trade insurance; and

(4) Title insurance, except that the following apply to this line: Sections 23-79-101(1), 23-79-109 — 23-79-111, 23-79-113, 23-79-116, 23-79-118, 23-79-119, and 23-79-202 — 23-79-205.

History. Acts 1959, No. 148, § 268; 1979, No. 691, § 1; A.S.A. 1947, § 66-3201; Acts 2001, No. 1604, § 79; 2007, No. 684, § 5; 2013, No. 355, § 12.

Amendments. The 2013 amendment, in the introductory language, substituted "Sections" for "This section and §§" and "do not apply" for "shall not apply"; rewrote (2); and, in (4), deleted "provisions shall" preceding "apply," and substituted "and 23-79-202 — 23-79-205" for "23-79-202, and 23-79-205."

Effective Dates. Acts 2007, No. 684, § 10, provided: "Sections 1 through 9 of this act take effect January 1, 2008."

23-79-107. Application — Statements as representations.

(a) A statement in an application or in negotiations for a life or accident and health insurance policy or annuity contract by or in behalf of the insured or annuitant are representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer.

(b) In any action to rescind any policy or contract or to recover thereon, if any misrepresentation with respect to a medical impairment is proved by the insurer and the insured or any other person having or claiming a right under the contract shall prevent full disclosure and proof of the nature of the medical impairment, then the misrepresentation shall be presumed to have been material.

(c) In any action to rescind any policy or contract or to recover thereon, a misrepresentation is material if there is a causal relationship between the misrepresentation and the hazard resulting in a loss under the policy or contract.

History. Acts 1989, No. 662, § 1; 2001, No. 1604, § 82; 2011, No. 1054, § 1.

Amendments. The 2011 amendment deleted (a)(3).

23-79-109. Filing and approval of forms.

(a)(1)(A)(i) No basic insurance policy, or annuity contract form, or application form when written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state unless the form has been filed with and approved by the Insurance Commissioner and, in the case of individual accident and health contracts, the rates have been filed with and approved by the commissioner.

(ii)*(a)* The commissioner may consider a nonprofit insurer's surplus levels in determining whether a proposed rate is excessive.

(b) Subdivision (a)(1)(A)(ii)*(a)* of this section does not apply to a nonprofit insurer that offers only limited scope dental benefits.

(B) This subsection shall not apply to:

(i) Policy or coverage forms for large commercial risks, as defined in subsection (g) of this section;

(ii) Commercial umbrella policy or coverage forms;

(iii) Excess umbrella policy or coverage forms;

(iv) Excess of loss policy or coverage forms;

(v) Public officials' liability policy or coverage forms;

(vi) Fiduciary liability policy or coverage forms;

(vii) Directors' and officers' liability policy or coverage forms;

(viii) Kidnap and ransom policy or coverage forms;

(ix) Political risk policy or coverage forms;

(x) Expropriation coverage policy or coverage forms;

(xi) Mortgage pool insurance policy or coverage forms;

(xii) Railroad protective liability policy or coverage forms;

(xiii) Equity loan programs, second mortgage coverage, policy or coverage forms;

(xiv) Highly protected risk forms;

(xv) Surety bonds;

(xvi) Policies, orders, endorsements, or forms of unique character designed for, and used with relation to, insurance upon a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life and accident and health insurance polices and are used at the request of the individual policyholder, contract holder, or certificate holder; or

(xvii) Policies, contracts, riders, endorsements, and certificates issued by surplus lines insurers.

(C) The exemption of a particular type of insurance policy form from the requirement that it be filed with the commissioner and expressly approved thereby is not to be taken by an insurer as meaning that any insurance effected by the use of such a form may in any fashion be inconsistent with the statutory and common law of this state that is properly applicable thereto.

(2) As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner.

(3) No group accident and health certificate of insurance may be extended to residents of this state under a group accident and health policy issued outside this state that does not include the provisions required for group policies issued in this state unless the commissioner determines that the provisions are not appropriate for the coverage provided. Upon request of the commissioner, copies of the group accident and health policies issued outside this state shall be made available on an informational basis.

(4) On and after January 1, 1990, all medicare supplement rates shall be based on a composite age basis only and shall not be based on any age banding or other groupings.

(5) Nothing in this subsection shall prohibit an insurer or hospital and medical service corporation issuing medicare supplement insurance policies from using its usual and customary underwriting procedures or excluding preexisting health conditions. However, no insurer shall refuse to issue a medicare supplement policy based solely on the age of the applicant.

(b)(1) Every filing shall be made not less than thirty (30) days in advance of any delivery. At the expiration of the thirty (30) days, the form or rate so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the commissioner.

(2) Approval of the form or rate by the commissioner shall constitute a waiver of any unexpired portion of the waiting period.

(3) The commissioner may extend by not more than an additional thirty (30) days the period within which he or she may so affirmatively approve or disapprove the form or rate by giving notice of the extension before expiration of the initial thirty-day period.

(4) At the expiration of the period as so extended, and in the absence of prior affirmative approval or disapproval, the form or rate shall be deemed approved.

(5) The commissioner may at any time, after notice and for cause shown, withdraw approval.

(c) Notification disapproving the form or withdrawing a previous approval shall state the grounds therefor.

(d) By order, the commissioner may exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof as specified in the order to which, in his or her opinion, this section may not practically be applied or the

filing and approval of which are, in his or her opinion, not desirable or necessary for the protection of the public.

(e) This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by that official, and upon the commissioner's written notice requiring the form to be submitted to him or her for the purpose. The same standards that are applicable to forms for domestic use shall apply to such forms.

(f) No policy or contract form providing coverage for personal automobile liability that provides for a policy term of less than six (6) months shall be approved by the commissioner or issued for delivery in this state and used by insurers on and after January 1, 1992. However, the provisions of this subsection shall not restrict premium payment options offered by insurers.

(g)(1) For purposes of this section, "large commercial risk" means an insured that has:

(A) A total premium of two hundred fifty thousand dollars ($250,000) or more for property and casualty insurance;

(B) At least twenty-five (25) full-time employees; and

(C) A full-time certified risk manager to procure property and casualty insurance. For purposes of this subsection, "certified risk manager" means a risk manager with one (1) or more of the following credentials:

(i) Associate in risk management;

(ii) Chartered property casualty underwriter; or

(iii) Certified risk manager.

(2) The exemption for large commercial risk policy or coverage forms set forth in subdivision (a)(1) of this section shall not apply to workers' compensation, or employers' liability or professional liability insurance, including, but not limited to, medical malpractice insurance.

(3)(A) In procuring coverage, a large commercial risk shall certify that it:

(i) Meets the eligible criteria for an exempt commercial policyholder set out in this subsection;

(ii) Is aware that the policy is unregulated for rates and forms; and

(iii) Has the necessary expertise to negotiate its own policy language.

(B) This certification shall be completed annually and remain on file with the producing agent or broker.

(h) If the commissioner deems that the review as to either rates or forms, or both, required by this section as to any particular line or lines of insurance, can be performed in some other manner that provides sufficient protection to the consumers of this state and results in greater efficiency in bringing new or modified products within the line to market, the approval required by this section may be waived for such period as is deemed appropriate, or until revoked.

(i)(1) If the commissioner disapproves a rate, the insurer may request that the commissioner provide the insurer with the filing an

actuarial analysis, interpretation of statistical data, and other methodology that was reviewed by the commissioner or his or her staff.

(2) The information required under subdivision (i)(1) of this section shall be provided within five (5) working days after the receipt of the request.

History. Acts 1959, No. 148, § 276; 1975, No. 841, § 1; 1979, No. 691, § 2; 1981, No. 809, § 13; 1985, No. 804, § 1; A.S.A. 1947, § 66-3209; Acts 1987, No. 268, § 1; 1989, No. 710, § 2; 1989, No. 815, § 1; 1991, No. 1123, § 11; 1992 (1st Ex. Sess.), No. 72, § 1; 1993, No. 901, § 39; 1999, No. 458, §§ 3, 4; 2001, No. 1604, §§ 84-87; 2009, No. 726, § 37; 2013, No. 1187, § 1; 2013, No. 1339, § 1.

Amendments. The 2009 amendment inserted (a)(1)(B)(xvii).

The 2013 amendment by No. 1187 added (i).

The 2013 amendment by No. 1339 added (a)(1)(A)(ii).

23-79-110. Forms and premium rates — Grounds for disapproval.

(a) The Insurance Commissioner shall disapprove a form filed under § 23-79-109, or withdraw a previous approval, only if the form:

(1) Is in violation of or does not comply with this code;

(2) Contains or incorporates by reference, when the incorporation is otherwise permissible, an inconsistent, ambiguous, or misleading clause, or an exception and a condition that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) Has a title, heading, or other indication of its provisions that is misleading; and

(4) Is printed or otherwise reproduced in such a manner that makes a provision of the form substantially illegible or not easily legible to persons of normal vision.

(b)(1) The commissioner shall disapprove a premium rate filed with an individual accident and health contract if the commissioner finds that the rate is not actuarially sound, is excessive, is inadequate, or is unfairly discriminatory.

(2) A rate is actuarially sound if it is:

(A) Supported by an actuarial analysis made by a member of the American Academy of Actuaries; and

(B) Based on generally accepted actuarial principles and methodologies that show the rate to be reasonable.

(3) An insurer's submission of an actuarially sound rate shall not foreclose the commissioner from relying upon a contrary opinion made by a member of the American Academy of Actuaries who utilized generally accepted actuarial principles and methodologies to contest the rate filed by the insurer.

(4) A rate is excessive if it is likely to produce a profit that is unreasonably high in relation to past and prospective loss experience for the form which the filing affects or if expenses are unreasonably high in relation to services given.

(5) A rate is not unfairly discriminatory if:

(A) It shows equitably the differences in expected losses and expenses; or

(B) Different premiums result for policyholders with like loss exposures but different expense factors or with like expense factors but different loss exposures, if the rates show the differences with reasonable accuracy.

(6) A rate is inadequate if the investment income attributable to the rate fails to satisfy projected losses and expenses for the form which the filing affects.

(c)(1) A rate on a particular policy form is approved when filed with the commissioner if the insurer has filed a loss ratio guarantee with the commissioner and complied with the terms of the loss ratio guarantee.

(2) A benefit is reasonable in relation to the premium so long as the insurer complies with the terms of the loss ratio guarantee.

(3) The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and contain at least the following:

(A) A recitation of the anticipated target loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(B) A guarantee that if the new rate takes effect the loss ratios in this state for the experience period in which the new rate takes effect and for each experience period thereafter until a new rate is filed, shall meet or exceed the loss ratio standards referred to in subdivision (a)(4) of this section;

(C) A statement or guarantee that affected policyholders in this state shall be issued a proportional refund based on premium earned of the amount necessary to bring the total loss ratio up to the loss ratio standards referred to in subdivision (a)(4) of this section;

(D) If nationwide loss ratios are used, then the total amount refunded in this state shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in this state on the policy form and divided by the total premium earned in a state on the policy form;

(E) The refund shall be made to a policyholder in this state who is insured under the applicable policy form on the last day of the experience period and whose refund would equal ten dollars ($10.00) or more;

(F) The refund in subdivision (c)(6)(C) of this section shall include interest from the end of the experience period until the date of payment;

(G) The payment of the refund shall be made during the third quarter of the year following the experience period for which a refund is determined to be due; and

(H) Refunds of less than ten dollars ($10.00) shall be aggregated by the insurer and paid to the State Insurance Department.

(4)(A) If the annual earned premium volume in this state under a policy form is less than one million dollars ($1,000,000) and therefore not actuarially credible, the loss ratio guarantee shall be based on the nationwide loss ratio for the policy form.

(B) If the total earned premium in this state is less than one million dollars ($1,000,000), the experience period shall be extended

until the end of the calendar year in which one million dollars ($1,000,000) of earned premium is attained.

(5)(A) An insurer shall submit a guarantee that the loss ratio in this state or nationally, if applicable, for the year at issue shall be independently audited at the insurer's expense.

(B) An audit shall be made in the second quarter of the year following the end of the experience period and the audited results reported to the commissioner at or before the date for filing the policy experience exhibit.

(6) An insurer shall file with the commissioner the following with a loss ratio guarantee:

(7) As used in this section:

(A)(i) "Experience period" means the period for a given rate filing for which a loss ratio guarantee is made beginning on the first day of the calendar year during which the rate first takes effect and ending on the last day of the calendar year during which the insurer earns one million dollars ($1,000,000) in premium on the form in this state or if the annual premium earned on the form in Arkansas is less than one million dollars ($1,000,000) nationally.

(ii) Successive experience periods shall be determined beginning on the first day following the end of the preceding experience period; and

(B) "Loss ratio" means the ratio of incurred claims to earned premium by number of years of policy duration for the combined durations.

(8)(A) An insurer whose rates on a policy form are approved according to a loss ratio guarantee shall provide a notice to an affected policyholder that advises that rates may be increased more than one (1) time a year.

(B) The notice shall be delivered to a new policyholder with policies subject to the loss ratio guarantee at or before the time of delivery of the policy.

(d) This section does not require an insurer to provide the notice required by this section on more than one (1) occasion to a policyholder while the policyholder is insured under the guaranteed form.

History. Acts 1959, No. 148, § 277; 1975, No. 841, § 2; 1985, No. 530, § 1; A.S.A. 1947, § 66-3210; Acts 1991, No. 398, § 1; 2001, No. 1604, §§ 88, 89; 2013, No. 1187, § 2.

A.C.R.C. Notes. As enacted by Acts 2013, No. 1187, subdivision (c)(6) appears to be missing language.

Amendments. The 2013 amendment added "and premium rates" in the section heading; added the subsection (a) designation; deleted (5); and added (b), (c), and (d).

23-79-114. Entitlement notwithstanding policy provisions — Health services performed by professionals not licensed under Arkansas Medical Practices Act.

(a)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy,

contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any service provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., the person entitled to benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under any of the examining boards found in § 17-80-101, as amended by §§ 17-95-301 — 17-95-304.

(2) Nothing in this subsection shall be construed to amend, alter, or repeal any laws relating to the licensing or use of hospitals.

(3) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement in effect prior to February 3, 1971.

(b)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, whenever such a policy, contract, plan, or agreement provides for payment or reimbursement for any service in the vision or human eye field provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., the person entitled to benefits or the person performing services under such a policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for such a service when the service is performed by any person licensed under the Arkansas Optometry Practices Act, § 17-90-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied his or her freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Arkansas Optometry Practices Act, § 17-90-101 et seq., by any insurer or agent or employee of the insurer or by any department, agency, or employee of this state.

(3)(A) Nothing herein shall be construed to enlarge or diminish the practice of optometry as defined by law in the Arkansas Optometry Practices Act, § 17-90-101 et seq., and, in accordance with state law, sole and complete authority regarding determination of those acts, services, procedures, and practices that constitute the practice of optometry in this state shall be vested in the State Board of Optometry.

(B) This section shall specifically include, but not be limited to, authority of the State Board of Optometry to define the parameters of management and comanagement of persons licensed under the Arkansas Optometry Practices Act, § 17-90-101 et seq., in the treatment and management of postoperative and therapeutic care of the human eye.

(4) The provisions of this subsection shall not apply to any policy, contract, plan, or agreement until persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and

§ 17-95-401 et seq., become entitled to reimbursement for services by the insurer in the vision or human eye field.

(5) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Arkansas Optometry Practices Act, § 17-90-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service in the vision or human eye field.

(c)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of the diagnosis, medical, mechanical, or surgical treatment of ailments of the human foot provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., the person entitled to benefits or person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed under the Arkansas Podiatry Practices Act, § 17-96-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Arkansas Podiatry Practices Act, § 17-96-101 et seq., by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of podiatry as defined by law in the Arkansas Podiatry Practices Act, § 17-96-101 et seq.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Arkansas Podiatry Practices Act, § 17-96-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service consisting of the diagnosis, medical, mechanical, and/or surgical treatment of ailments of the human foot.

(d)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services, provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., the person entitled to benefits or persons providing services under the policy, contract, plan, or agreement are entitled to payment or reimbursement on an equal basis for the service when the service is

provided by any person licensed as a psychologist under § 17-97-201 et seq. and operating within his or her area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or § 17-97-201 et seq. by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of psychology as defined by law in § 17-97-201 et seq.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or persons licensed as psychologists under § 17-97-201 et seq. shall be entitled to payment or reimbursement on an equal basis for services consisting of psychological evaluation, counseling, psychotherapy, or related mental health services.

(e)(1) Notwithstanding any provision of any accident and health insurance contract or any group accident and health insurance contract or blanket accident and health insurance contract as provided for in this section and §§ 23-79-101 — 23-79-107, 23-79-109 — 23-79-113, 23-79-115 — 23-79-128, 23-79-131 — 23-79-134, and 23-79-202 — 23-79-210, benefits shall not be denied thereunder for any health service performed by any person licensed pursuant to the provisions of the Arkansas Dental Practice Act, § 17-82-101 et seq., if the service performed was within the lawful scope of the person's license and the contract would have provided benefits if the service had been performed by a holder of a license issued pursuant to the provisions of the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Arkansas Dental Practice Act, § 17-82-101 et seq., by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of dentistry as defined by the Arkansas Dental Practice Act, § 17-82-101 et seq.

(f)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, in cases in which the policy, contract, plan, or agreement provides for payment or reimbursement for any anesthesia services provided by persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., the person entitled to benefits or the persons providing services under the policy,

contract, plan, or agreement are entitled to the same method of payment for the service when the service is provided by any person licensed as a certified registered nurse anesthetist and operating within his or her area of competence.

(2) No person entitled to benefits under this subsection shall be denied freedom of choice to select any practitioner licensed under § 17-87-302 by any insurer or agency or employee of the insurer or by any department, agency, or employee of this state.

(3) Nothing in this subsection shall be construed to enlarge or diminish the practice of certified registered nurse anesthetists under § 17-87-302.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or persons licensed as certified registered nurse anesthetists under § 17-87-302 shall be entitled to the same method of payment for anesthesia services.

(g)(1) Notwithstanding any provision of any individual or group policy of accident and health insurance or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, whenever the policy, contract, plan, or agreement provides for payment or reimbursement for any service in the audiology field provided by persons licensed as audiologists under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., the person entitled to benefits or the person performing services under the policy, contract, plan, or agreement is entitled to payment or reimbursement on an equal basis for the service when the service is performed by any person licensed as an audiologist under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq.

(2) No person entitled to benefits under this subsection shall be denied his or her freedom of choice of any practitioner licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., by any insurer or agent or employee of the insurer or by any department, agency, or employee of this state.

(3)(A) Nothing in this subsection shall be construed to enlarge or diminish the practice of audiology as defined under § 17-100-103.

(B) Under state law, sole and complete authority regarding determination of those acts, services, procedures, and practices that may be reimbursed on an equal basis shall be vested in the Board of Examiners in Speech-Language Pathology and Audiology.

(C) This section shall specifically include, but not be limited to, the authority of the board to define the parameters of management and comanagement of persons licensed under the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., in the treatment and management of hearing and disorders of hearing.

(4) The purpose of this subsection is to ensure that persons licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., or the Licensure Act of Speech-Language Pathologists and Audiologists, § 17-100-101 et seq., shall be entitled to payment or reimbursement on an equal basis for service in the audiology field.

(5) The failure to comply with any provision in this subsection shall be deemed an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq., and may be punished by fines and penalties established under §§ 23-60-108, 23-66-210, and 23-66-215.

History. Acts 1959, No. 148, § 279; 1971, No. 34, §§ 1-3; 1971, No. 531, §§ 1-5; 1975, No. 303, §§ 1-4; 1975, No. 741, §§ 1-4; 1981, No. 196, §§ 1-3; A.S.A. 1947, §§ 66-3212, 66-3212n, 66-3212.2 — 66-3212.9, 66-3212.2n, 66-3212.3n, 66-3212.5n, 66-3212.7n; Acts 1993, No. 577, § 1; 1993, No. 1271, § 1; 2001, No. 1604, § 92; 2003, No. 1455, § 2; 2005, No. 1995, § 1.

23-79-118. Noncomplying forms.

CASE NOTES

Validity.

There are no cases in which an Arkansas court has declared an insurance policy invalid on the basis of § 23-80-206(a), and § 23-79-118 precludes any relief based on noncompliance with § 23-80-206. Francis v. Protective Life Ins. Co., 98 Ark. App. 1, 249 S.W.3d 828 (2007), appeal dismissed, 371 Ark. 285, 265 S.W.3d 117 (2007).

23-79-119. Construction of policies.

(a) Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made a part of the policy.

(b) All insurance contracts that are issued for specific terms and that may be renewed for subsequent terms at the option of the insured or the insurer shall be construed from and after their respective dates of renewal as being new contracts to the extent of having incorporated therein all applicable public policy that by statute or regulation may have become applicable to those contracts in the interval between:

(1) Original issuance or last renewal; and

(2) The renewal following the newly applicable statement of public policy.

(c)(1) Except as provided in this section, a health insurance issuer that provides individual health insurance coverage for major medical benefits to an individual shall renew or continue in force that coverage at the option of the individual.

(2) General Exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based on only one (1) or more of the following:

(A) Nonpayment of the Premium. The individual has failed to pay premiums or contributions under the terms of the health insurance coverage or the issuer has not received timely premium payments;

(B) Fraud. The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(C) Termination of the Plan. The issuer is ceasing to offer major medical coverage in the individual market under applicable state or federal law;

(D) Movement Outside the Service Area. In the case of a health insurance issuer that offers health insurance for major medical coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business, but only if the individual major medical coverage is terminated under this subdivision (c)(2)(D) uniformly without regard to any health-status related factor of covered individuals; and

(E) Association Membership Ceases. In the case of health insurance for major medical coverage that is made available in the individual market only through one (1) or more bona fide associations, the membership of the individual in the association, as the basis on which the coverage is provided, ceases but only if the major medical coverage is terminated under this subdivision (c)(2)(E) uniformly without regard to any health status-related factor of covered individuals.

(3) Requirements for Uniform Termination of Coverage — Particular Type of Coverage Not Offered. In the case in which an insurer decides to discontinue offering a particular type of health insurance providing major medical coverage offered to the individual market, coverage of this type may be discontinued by the issuer only if:

(A) The issuer provides to each covered individual with coverage of this type in the market notice of the discontinuation at least ninety (90) days before the date of the discontinuation of the coverage;

(B) The issuer offers to each individual in the individual market with coverage of this type the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in the market; and

(C) In exercising the option to discontinue coverage of this type and in offering the option of coverage under subdivision (c)(3)(B) of this section, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(4) Discontinuance of Such Coverage — In General. Subject to this section, in any case in which a health insurance issuer elects to discontinue offering all health insurance providing major medical coverage in the individual market in this state, health insurance coverage may be discontinued by the issuer only if the issuer provides to the Insurance Commissioner and to each individual notice of the

discontinuance at least one hundred eighty (180) days before the date of expiration of the coverage.

(5) Prohibition on Market Reentry. In the case of a discontinuation in the individual market under this section, the issuer may not provide for the issuance of any health insurance providing major medical coverage in the market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(6) Exception for Uniform Modification of Coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance providing major medical coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

(7) Application to Coverage Offered Only Through Associations. In applying this section in the case of health insurance providing major medical coverage that is made available by a health insurance issuer in the individual market through only one (1) or more associations, a reference to an "individual" includes a reference to such an association of which the individual is a member.

(8) For purposes of this section, the terms or phrases "health insurance issuer", "health insurance coverage" or "coverage", "Insurance Commissioner", "network plan", "health status-related factor", "bona fide association", "individual market", and "eligible individual" shall have the same meaning as defined in § 23-86-303.

(d) The commissioner may promulgate rules that are necessary to implement and enforce this section for the protection of policyholders.

History. Acts 1959, No. 148, § 285; 1981, No. 520, § 1; A.S.A. 1947, § 66-3218; Acts 1993, No. 901, § 40; 1999, No. 881, § 13; 2011, No. 886, § 1.

Amendments. The 2011 amendment substituted "this section" for "this subsection" throughout (c); substituted "insurance" for "issuance" in (c)(3)(B); substituted "have the same meaning as defined in § 23-86-303" for "be defined pursuant to the definitions contained in § 23-86-303" in (c)(8); and added (d).

23-79-120. Binders.

CASE NOTES

Agents.

Trial court properly determined that an insurance agent was not a franchisee under the Arkansas Franchise Practices Act because the agent did not have the unqualified authority to sell policies or commit the insurance company to an insurance contract other than a temporary binder, which, by definition, could have been cancelled at any time at the discretion of the company. Gunn v. Farmers Ins. Exch., 2010 Ark. 434, — S.W.3d — (2010), rehearing denied, — Ark. —, — S.W.3d —, 2011 Ark. LEXIS 382 (Jan. 6, 2011).

23-79-121. Delivery of policy.

(a)(1) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled to receive it, within a reasonable period of time after its issuance, except when a condition required by the insurer has not been met.

(2)(A) The insurer may mail or deliver an electronic copy of the policy to the insured or to the person entitled to receive it.

(B) The insurer shall retain the electronic transmittal and an electronic or imaged copy of the policy as a part of the insurer's records.

(b)(1) In the event the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any property or motor vehicle and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to the property or vehicle is insured, then a duplicate of the policy, or a certificate of insurance setting forth the name and address of the insurer, insurance classification in the case of a vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same information, shall be delivered by the agent through whom the insurance was procured to each vendee, mortgagor, or pledgor named in the policy.

(2) No insurer shall have any responsibility or liability with respect to compliance or noncompliance with any requirement of this subsection.

(3) This subsection does not apply to insurance of aircraft.

History. Acts 1959, No. 148, § 287; A.S.A. 1947, § 66-3220; Acts 2005, No. 506, § 39.

23-79-123. Renewal by certificate.

(a)(1) Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer upon a currently authorized policy form and at the premium rate then required for that type of policy, for a specific additional period or periods by certificate or by endorsement of the policy or by electronic certificate or electronic endorsement properly executed and without requiring the issuance of a new policy.

(2) The insurer shall retain the electronic transmittal and a copy of the certificate or endorsement as a part of the insurer's records.

(b) By reasonable rules and regulations or by order the Insurance Commissioner may deny the use of such certificates for renewal of such types of policies or in such circumstances as may be necessary or advisable to protect insureds who may otherwise hold forms of policies which no longer contain all of the benefits or conditions applicable under similar policies currently issued by the same insurer.

(c) The provisions of this section shall not apply to policies issued for large commercial risks.

History. Acts 1959, No. 148, § 289; A.S.A. 1947, § 66-3222; Acts 1999, No. 458, § 7; 2005, No. 506, § 40.

23-79-125. Payment by insurer — Discharge.

CASE NOTES

Discharge.

Where a life insurance company was faced with legitimate claims from both the widow and the former wife, who was still the named beneficiary, the protection offered by subsection (b) of this section was not available because payment to the widow would not have discharged it from having to pay a claim from the former wife. Primerica Life Ins. Co. v. Watson, 362 Ark. 54, 207 S.W.3d 443 (2005).

Pursuant to this section, where none of the interpleaded bank defendants had given written notice to an insurer that they intended to claim any interest in policy proceeds after insureds' home and personal property were destroyed by fire, the insurer could have availed itself of the statutory protection rather than filing an interpleader action that did nothing but delay payment of the proceeds of the policy. Farm Bureau Mut. Ins. Co. of Ark., Inc. v. Guyer, 2011 Ark. App. 710, — S.W.3d — (2011).

23-79-129. Coverage of newborn infants.

(a)(1) Every accident and health insurance policy, contract, certificate, or health care plan sold, delivered, issued, or offered for sale, issue, or delivery in this state, other than coverage limited to expenses from accidents or specified diseases, whether an individual or group policy, contract, certificate, or plan that covers the insured and members of the insured's family, shall include coverage for newborn infant children by the insured from the moment of birth.

(2) The coverage of newborn children shall be the same as is provided for other members of the insured's family and shall include:

(A) Coverage for illness, injury, congenital defects, and premature birth;

(B) Coverage for tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other genetic disorders for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law; and

(C) Subject to minimum benefits required by § 23-99-404, coverage to pay for routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

(b) The insurer may require that the insured give notice to his or her insurer of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

(c) The Insurance Commissioner shall not approve any policy or contract to be sold, issued, or offered for sale in this state unless it shall

specifically include the coverage required in this section for newborn infants.

History. Acts 1975, No. 298, §§ 1-3; 1981, No. 481, § 3; 1983, No. 357, § 1; 1983, No. 522, § 27; A.S.A. 1947, §§ 66-3248 — 66-3250; Acts 1987, No. 456, § 15; 1987, No. 573, § 3; 1987 (1st Ex. Sess.) No. 12, § 1; 1987 (1st Ex. Sess.) No. 60, § 1; 1995, No. 113, § 2; 2001, No. 1604, § 99; 2003, No. 1293, § 3; 2013, No. 428, § 2.

Amendments. The 2013 amendment substituted "genetic disorders" for "disorders of metabolism" in (a)(2)(B).

23-79-130. Impairment of speech or hearing.

(a) Every accident and health insurer, hospital or medical service corporation, or health maintenance organization transacting accident and health insurance or providing health coverage in the State of Arkansas, which delivers or issues for delivery or renews, extends, or modifies accident and medical coverage on an expense-incurred service or prepaid basis, shall provide coverage for the necessary care and treatment of loss or impairment of speech or hearing, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as other covered services in the policies or contracts.

(b) This section does not apply to disability income, specified disease, hospital indemnity, or accident-only policies.

(c) The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

(d) The additional coverage provided for in this section shall not apply to hearing instruments or devices.

History. Acts 1985, No. 303, §§ 1, 4; A.S.A. 1947, §§ 66-3260, 66-3263; Acts 2005, No. 1995, § 2.

23-79-136. Agreement for insurer to invest premium prohibited.

(a) It is unlawful for any insurance company authorized to do business in this state to issue or offer for sale or issue in this state any policy of insurance under which the insurer agrees to invest a portion of the policy premium, whether for one (1) or more years, and hold a portion of the policy premium for investment in its own name either directly or indirectly, or as trustee for the benefit of the insured or for the benefit of a certain class of policyholders.

(b) Any insurance company issuing or offering to issue any policy in violation of the provisions of subsection (a) of this section upon conviction shall be fined in any sum not less than five hundred dollars ($500) nor more than five thousand dollars ($5,000), and in addition, the authority of the insurance company to do business in this state may be revoked.

(c)(1) This section shall not be construed to prohibit the offer or sale of a variable annuity contract issued, or variable benefit payable, in compliance with the applicable requirements of the Arkansas Insurance Code, the Securities Act of 1933, the Investment Company Act of 1940, and the Arkansas Securities Act, § 23-42-101 et seq.

(2) This section shall not apply to contracts with respect to amounts maintained by insurers in such group pension, profit-sharing, and annuity separate accounts as may be authorized by law.

(3) This section shall not apply to policy provisions permitting benefits to be left on deposit with the insurer at a specified rate of interest.

History. Acts 1967, No. 185, §§ 1-3; A.S.A. 1947, §§ 66-3245 — 66-3247; Acts 2005, No. 1994, § 441.

23-79-138. Information to accompany policies.

(a) The following information shall accompany every policy of life insurance, accident and health insurance, property insurance, casualty insurance, or title insurance issued and covering risks located, resident, or to be performed in the State of Arkansas:

(1) The complete address and telephone number, including a toll-free number if available, of the policyholder's service office of the company issuing the policy;

(2) The name, address, and telephone number of the producer or agency soliciting the policy if applicable; and

(3) The address and telephone number, including a toll-free number if available, of the State Insurance Department.

(b) A person who fails to comply with this section is subject to the penalties provided in § 23-60-108.

(c) The Insurance Commissioner may adopt appropriate rules to enforce and carry out the intent and purposes of this section.

History. Acts 1987, No. 197, §§ 1-3; 2001, No. 1604, § 102; 2009, No. 726, § 38.

Amendments. The 2009 amendment, in (a), inserted "or title insurance" and deleted "after January 1, 1988" following "issued" in the introductory language, and substituted "producer or agency" for "agent" in (a)(3); deleted "and regulations" following "rules" in (c); and made related and minor stylistic changes.

23-79-139. Benefits for alcohol or drug dependency treatment.

(a)(1) Every insurer, hospital and medical service corporation, and health maintenance organization transacting accident and health insurance in this state shall offer and make available under all group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service, or prepaid basis benefits for the necessary care and treatment of alcohol and other drug dependency that are not less favorable than for physical illness generally, subject to

the same durational limits, dollar limits, deductibles, and coinsurance factors, except as provided in this section.

(2)(A) The offer for these benefits shall be subject to the right of the policy or contract holder to reject the coverage or select any alternative level of benefits.

(B) The rejection by the policy or contract holder shall be in writing.

(b) Any benefits provided under alcohol or drug dependency coverage shall be determined as necessary care and treatment in an alcohol or drug dependency treatment facility or care and treatment in a hospital.

(c) Treatment may include detoxification, administration of a therapeutic regimen for the treatment of alcohol or drug dependent or substance abusing persons, and related services.

(d) The facility or unit may be:

(1) A unit within a general hospital or an attached or freestanding unit of a general hospital;

(2) A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital; or

(3) A freestanding facility specializing in treatment of persons who are substance abusers or are alcohol or drug dependent, and may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse facilities", "social setting detoxification facilities", and "medical detoxification facilities", or by other names if the purpose is to provide treatment of alcohol or drug dependent or substance abusing persons, but shall not include halfway houses or recovery farms.

(e) Every policy or contract of insurance that provides benefits for alcohol or drug dependency treatment and that provides total annual benefits for all illnesses in excess of six thousand dollars ($6,000) is subject to the following conditions:

(1) The policy or contract shall provide, for each twenty-four-month period, a minimum benefit of six thousand dollars ($6,000) for the necessary care and treatment of alcohol or drug dependency;

(2) No more than one-half (½) of the policy's or contract's maximum benefits for alcohol or drug dependency for a twenty-four-month period shall be paid for the necessary care and treatment of alcohol or drug dependency in any thirty-consecutive-day period; and

(3) The policy or contract shall provide a minimum benefit of twelve thousand dollars ($12,000) for the necessary care and treatment of alcohol or drug dependency for the life of the recipient of benefits.

(f) For the purposes of this section, the term "alcohol or drug dependency treatment facility" shall mean a public or private facility, or unit in a facility, that is engaged in providing treatment twenty-four (24) hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician, and that is also properly licensed or accredited to provide those services by the Division of Behavioral Health Services.

(g) Nothing in this section shall prohibit any certificate or contract from requiring the most cost-effective treatment setting to be utilized

by the person undergoing necessary care and treatment for alcohol or drug dependency.

(h) As used in this section, "alcohol or drug dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

(i) This section shall apply to group policies or contracts delivered or issued for delivery or renewed in this state after November 17, 1987, but shall not apply to blanket short-term travel accident only, limited or specified disease, conversion policies or contracts, nor to policies or contracts referred to as medicare supplement policies, designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act.

History. Acts 1987, No. 1047, §§ 1-6; 2001, No. 1604, § 103; 2013, No. 1107, § 43.

Amendments. The 2013 amendment substituted "Division of Behavioral Health Services of the Department of Human Services" for "Bureau of Alcohol and Drug Abuse Prevention of the Department of Health" in (f).

23-79-140. Mammograms.

(a)(1) "Mammography" means radiography of the breast.

(2) "Screening mammography" is a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a physician's interpretation of the results of the procedure.

(3) "Diagnostic mammography" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the physician interpreting the study, and additional views are obtained as needed. A physical examination of the breast by the interpreting physician to correlate the radiologic findings is often performed as part of the study.

(b) Every accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider in the State of Arkansas shall offer, after January 1, 1990, to each master group contract holder as an optional benefit, coverage for at least the following mammogram screening of occult breast cancer:

(1) A baseline mammogram for a woman covered by such a policy who is thirty-five (35) to forty (40) years of age;

(2) A mammogram for a woman covered by such a policy who is forty (40) to forty-nine (49) years of age, inclusive, every one (1) to two (2) years based on the recommendation of the woman's physician;

(3) A mammogram each year for a woman covered by such a policy who is at least fifty (50) years of age;

(4) Upon recommendation of a woman's physician, without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer; and

(5) Insurance coverage for screening mammograms will not prejudice coverage for diagnostic mammograms as recommended by the woman's physician.

(c)(1) The insurers shall pay not less than fifty dollars ($50.00) for each screening mammogram, which shall include payment for both the professional and technical components.

(2) In case of hospital out-patient screening mammography, and comparable situations, when there is a claim for professional sevices separate from the claim for technical services, the claim for the professional component will not be less than forty percent (40%) of the total fee.

(d) Furthermore, no insurer shall pay for mammographies performed in an unaccredited facility after January 1, 1990.

(e) After January 1, 2014, an accident and health insurance company, hospital service corporation, health maintenance organization, or other accident and health insurance provider shall use the Healthcare Common Procedure Coding System G code for digital mammography and reimburse those codes at a minimum of one and five tenths (1.5) times the Medicare reimbursement rate for those codes until a Current Procedural Terminology code is established.

History. Acts 1989, No. 292, §§ 2-4, 6; 1995, No. 508, § 2; 2001, No. 1604, § 104; 2013, No. 1259, § 2.

A.C.R.C. Notes. Acts 2013, No. 1259, § 1, provided: "Legislative findings.

"(a) The General Assembly finds that:

"(1) Health insurance payments to healthcare providers are primarily driven by Current Procedural Terminology (CPT) codes;

"(2) If a Current Procedural Terminology code is not available for a healthcare procedure, temporary Healthcare Common Procedure Coding System (HCPCS) G codes are used until a Current Procedural Terminology code is established;

"(3) In the struggle against breast cancer, digital mammography provides a powerful proven tool for early detection of disease, facilitating early intervention and increasing the chances for a complete recovery; and

"(4) There is limited access to digital mammography service particularly in rural areas of the state because of the significant increase in the cost of equipment and time and the lack of adjustment of payment."

Amendments. The 2013 amendment added (e).

23-79-141. Children's Preventive Health Care Act.

(a) Title. This section shall be known and may be cited as the "Children's Preventive Health Care Act".

(b) Declaration of Purposes. The purpose of this section is to assure that all children eighteen (18) years of age and younger are provided with insurance coverage for preventive health care services during their formative years in order to facilitate early detection and prevention of physical and mental illness, thereby avoiding the risks of the

extreme costs associated with many preventable childhood diseases. In addition to improving the health of children, providing insurance coverage for children's preventive health care services enhances the care-giving skills of parents and helps strengthen the family unit. Providing insurance coverage for children's preventive health care will also reduce the disruption to the emotional and financial well-being of families that often accompanies physical and mental illness among children.

(c) Definitions. As used in this section:

(1) "Children's preventive health care services" means physician-delivered or physician-supervised services for eligible dependents from birth through eighteen (18) years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards for the purposes of this section; and

(2) "Periodic preventive care visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

(d) Applicability.

(1) Every accident and health insurer, hospital or medical service corporation, health maintenance organization, fraternal benefit society, and self-insured plan transacting accident and health insurance or providing accident and health coverage in this state that delivers, issues for delivery in this state, or renews, extends, or modifies accident and health policies, contracts, certificates, and plans providing hospital and medical coverage on an expense-incurred, service, or prepaid basis, which contracts provide coverage for a family member of the insured person, shall provide to the contract holder coverage for periodic preventive care visits for covered persons from the moment of birth through eighteen (18) years of age.

(2) This section does not apply to disability income, specified disease, medicare supplement, hospital indemnity, or accident-only policies.

(e) Coverage.

(1) Each accident and health insurance policy, contract, certificate, or plan providing benefits for children's preventive health care services on a periodic basis shall include twenty (20) visits at approximately the following age intervals:

(A) Birth;
(B) Two (2) weeks;
(C) Two (2) months;
(D) Four (4) months;
(E) Six (6) months;
(F) Nine (9) months;
(G) Twelve (12) months;
(H) Fifteen (15) months;
(I) Eighteen (18) months;

(J) Two (2) years;
(K) Three (3) years;
(L) Four (4) years;
(M) Five (5) years;
(N) Six (6) years;
(O) Eight (8) years;
(P) Ten (10) years;
(Q) Twelve (12) years;
(R) Fourteen (14) years;
(S) Sixteen (16) years; and
(T) Eighteen (18) years.

(2) An accident and health insurance policy, contract, certificate, or plan may provide that children's preventive health care services that are rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single physician during the course of one (1) visit.

(f) Reimbursement, Coinsurance, and Deductibles.

(1) The benefits that are mandated by this section shall be reimbursed at levels established by the Insurance Commissioner.

(2)(A) Benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy. This exemption shall be explicitly stated in the policy.

(B) All other children's preventive health care services will be subject to copayment, coinsurance, deductible, or dollar limit provisions in the accident and health insurance policy.

History. Acts 1989, No. 860, § 1; 1995, No. 685, § 1; 2001, No. 1604, §§ 105, 106, 107; 2011, No. 760, § 14.

Amendments. The 2011 amendment deleted "that shall not exceed those established for the same services under the Medicaid program in the State of Arkansas" at the end of (f)(1).

23-79-146. Subrogation recovery.

RESEARCH REFERENCES

ALR. Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation. 125 A.L.R.5th 1.

CASE NOTES

Construction.

Insurer properly sought general subrogation benefits from a third-party tortfeasor under this section. The circuit court erred in its interpretation of § 23-89-207 in conjunction with this section. Progressive Halcyon INS. v. Saldivar, 2013 Ark. 69, — S.W.3d — (2013).

23-79-147. Prescription medication.

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner of the State Insurance Department;

(2) "Insurance policy" means any individual, group, or blanket policy, contract, or evidence of coverage written, issued, amended, delivered, or renewed in this state, or which provides such insurance for residents of this state by an insurance company, hospital medical corporation, or health maintenance organization; and

(3) "Medical literature" means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 107 Stat. 591 (1993), 42 U.S.C. § 1395x(t)(2)(B), as amended.

(b) An insurance policy that provides coverage for prescription drugs shall not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed if:

(1) The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more of these standard reference compendia:

(A)(i) The American Hospital Formulary Service Drug Information;

(ii) The National Comprehensive Cancer Network Drugs and Biologics Compendium;

(iii) The Elsevier Gold Standard's Clinical Pharmacology; or

(B) The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature; or

(2) Other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by an insurer at the insurer's discretion.

(c) Coverage of a drug required by subsection (b) of this section includes medically necessary services associated with the administration of the drug, provided that such services are covered by the insurance policy.

(d) Subsection (b) of this section shall not be construed to do any of the following:

(1) Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;

(2) Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration; or

(3) Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

History. Acts 1995, No. 1231, §§ 1, 2; 1999, No. 466, § 1; 2009, No. 270, § 1.

Amendments. The 2009 amendment deleted (b)(1)(B), redesignated the remaining text accordingly, inserted (b)(1)(B)(ii), (b)(1)(B)(iii), and (b)(2), and made related and minor stylistic changes.

23-79-152. Cancellation, increase in premium, and negative risk rating prohibited when insured not at fault.

(a) Except as provided in subsection (c) of this section, when a person is innocent of any negligent or intentional act that was the proximate cause of an accident or injury whether or not a claim is filed under any policy or contract of insurance, no insurer authorized to transact the business of motor vehicle liability insurance in this state shall solely as a result of the accident or injury:

(1) Cancel the person's insurance policy or contract;

(2) Increase the premium during the term or upon renewal of the person's insurance policy or contract; or

(3) Lower or otherwise negatively impact the risk rating of the person.

(b) Any insurer that violates the provisions of this section shall be subject to the procedure and penalties provided under the Trade Practices Act, § 23-66-201 et seq.

(c) Nothing in this section shall prevent an insurer from canceling, not renewing, or revising the rating of an insurance policy if the insurer is otherwise permitted to do so by statute or regulation.

History. Acts 2005, No. 1194, § 1.

23-79-153. Health insurance — Closing a block of business.

(a) As used in this section:

(1) "Block of business" means a particular policy form or contract other than a group policy form or contract providing health insurance coverage that includes distinct benefits, services, and terms individually underwritten and issued by a carrier to one (1) or more individuals residing in the State of Arkansas;

(2) "Carrier" means an entity subject to the insurance laws of the State of Arkansas or the jurisdiction of the Insurance Commissioner that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization, or a hospital medical service corporation;

(3) "Closed block of business" means a block of business that a carrier ceases to actively offer or sell to new applicants; and

(4)(A) "Health insurance coverage" means benefits consisting of medical, pharmaceutical, surgical, hospitalization, or similar goods or services for the purpose of preventing, alleviating, curing, or

healing human illness provided directly or indirectly through insurance, reimbursement, or otherwise, including:

(i) Items and services paid under any policy or contract individually underwritten and issued by a carrier; and

(ii) Without limitation, the following classifications of individual policies or individual contracts offered by a carrier:

(a) Comprehensive major medical;

(b) Critical illness and specified disease;

(c) Dental;

(d) HMO and managed care;

(e) Industrial health;

(f) Medical and surgical outpatient benefits;

(g) Supplemental hospital indemnity; and

(h) Vision.

(B) "Health insurance coverage" does not include policies or contracts covering only:

(i) Accident, credit, disability income, or long-term care insurance;

(ii) Automobile medical payment insurance;

(iii) A Medicare supplemental policy as defined in 42 U.S.C. § 1395ss(g)(1), as it existed on January 1, 2005; or

(iv) Claims under the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.

(b)(1) A block of business shall not be closed by a carrier unless the carrier pools the experience of the closed block of business with all blocks of business within the same classification previously closed by the carrier for the purpose of determining the percentage premium rate increase of any policy or contract within the closed block of business.

(2) The carrier shall not impose a rate penalty or surcharge under subdivision (b)(1) of this section beyond that which reflects the experience of the combined pool.

(c) The commissioner may approve other rate increases based upon:

(1) The size of the rate action;

(2) The experience of policy forms within a pool;

(3) The remaining amount of health insurance coverage in force by policy or contract form; and

(4) Other factors the commissioner considers appropriate.

(d)(1) Unless an insurer presents evidence satisfactory to the commissioner to the contrary, a block of business shall be presumed to be closed if the block of business has been in existence for more than twenty-four (24) months and:

(A) For a period of twenty-four (24) months, the number of contracts for the block of business has decreased by twelve percent (12%) or more; or

(B) The block of business has fewer than one hundred (100) policies or contracts in the State of Arkansas.

(2)(A) The fact that a block of business does not meet one (1) of the presumptions set forth in this subsection shall not preclude a different determination by the commissioner .

(B) At the request of an insurer adversely affected by the commissioner's determination, the commissioner shall schedule a hearing within thirty (30) days after receipt of the request for a hearing.

(3)(A) The closed block of business for a class of policies or contracts shall be determined at the time of a rate filing of any block of business within the class.

(B) In addition, other blocks of business within the same class shall be reviewed before submitting a proposed rate increase for the block of business.

(C) A justification for excluding the block of business from the closed block of business shall be included as part of the proposed rate increase.

(e)(1) A carrier shall notify the commissioner in writing within thirty (30) days of its decision to close a block of business.

(2) The carrier shall provide any additional information requested by the commissioner within:

(A) Fifteen (15) business days of the request; or

(B) A later time if allowed by the commissioner.

(f) A carrier shall preserve for a period of not less than five (5) years in an identified location that is readily accessible for review by the commissioner all books and records relating to any action taken by the carrier under subsection (b) of this section.

(g) A carrier with the purpose of evading this section shall not:

(1) Offer or sell any policy or contract; or

(2) Provide false or misleading information about the active or closed status of a block of business.

History. Acts 2005, No. 2293, § 1; 2007, No. 827, §§ 185, 186; 2009, No. 537, § 1.

Amendments. The 2009 amendment, in (a), inserted "other than a group policy form or contract," "individually underwritten and," and "residing in the State of Arkansas" in (a)(1), and rewrote (a)(4); rewrote (b); inserted (c), (d)(2)(B), (d)(3), (e)(2)(B), deleted (e)(1)(B), deleted (g) and (h), and redesignated accordingly; and made related and minor stylistic changes.

23-79-154. Reimbursement for physician assistant services.

(a) As used in this section, "health plan" means any group, blanket, or individual accident and health insurance policy, contract, or plan issued in this state by an insurance company, a hospital medical service corporation, or a health maintenance organization, provided that nothing in this subchapter shall apply to accident only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.

(b) A health plan shall not refuse to reimburse a physician at the full rate for health care services provided by a physician assistant if the practice complies with the laws of this state.

(c) A health plan shall not impose a practice or supervision restriction on a physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of this state.

History. Acts 2007, No. 458, § 1.

23-79-155. Commercial general liability insurance.

(a) A commercial general liability insurance policy offered for sale in this state shall contain a definition of "occurrence" that includes:

(1) Accidents, including continuous or repeated exposure to substantially the same general harmful conditions; and

(2) Property damage or bodily injury resulting from faulty workmanship.

(b) This section is not intended to restrict or limit the nature or types of exclusions from coverage that an insurer may include in a commercial general liability insurance policy.

History. Acts 2011, No. 604, § 2.

A.C.R.C. Notes. Acts 2011, No. 604, § 1, provided: "Findings and purpose.

"(a) It is found and determined by the General Assembly that:

"(1) Arkansas court decisions have caused uncertainty over whether the coverage provided to an insured under a commercial liability insurance policy will include damages caused by faulty workmanship;

"(2) Insurance consumers purchase commercial liability insurance coverage for substantial premiums in good faith for the express purpose of limiting their liability for faulty workmanship; and

"(3) An insurer should not be allowed to collect premiums to provide coverage against defects and then contest, deny, or fail to pay claims caused by faulty workmanship unless the insurer and insured have freely negotiated a specific exclusion from the coverage.

"(b) It is the purpose of this act to allow an insurance consumer to safely purchase commercial liability insurance coverage at a fair price to insure against the risk of property damage or bodily injury resulting from faulty workmanship."

23-79-156. Health insurance exchange — Coverage of abortions prohibited — Definitions — Findings.

(a) As used in this section:

(1) "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child;

(2) "Elective abortion" means an abortion for any reason other than:

(A)(i) To prevent the death of the mother upon whom the abortion is performed.

(ii) However, an abortion shall not be deemed an elective abortion to prevent the death of the mother based on a claim or diagnosis that without the abortion the mother will engage in conduct that will result in her death; or

(B) In a pregnancy resulting from rape or incest; and

(3) "Qualified health plan" means a health plan that meets the requirements under 42 U.S.C. § 18021, as it existed on January 1, 2013.

(b) The General Assembly finds that:

(1) Congress enacted and the President signed into law the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148; and

(2) In the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, states are explicitly permitted to pass laws prohibiting qualified health plans offered through a health insurance exchange in their state from offering abortion coverage.

(c)(1) In accordance with the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, a qualified health plan offered through a health insurance exchange established in this state shall not include elective abortion coverage.

(2) This section does not prevent an individual from purchasing optional supplemental coverage for elective abortions for which a separate premium shall be paid in the health insurance market outside of the state health insurance exchange as provided in subsection (d) of this section.

(d) An issuer of a health plan that offers optional supplemental abortion coverage offered in the health insurance market outside of the state health insurance exchange shall:

(1)(A) Calculate the premium for optional supplemental abortion coverage so that the premium fully covers the estimated cost of an elective abortion for an individual who enrolls for elective abortion coverage.

(B)(i) The insurer shall determine the premium required under subdivision (d)(1)(A) of this section on an average actuarial basis.

(ii)*(a)* In making the calculation required under subdivision (d)(1)(B)(i) of this section, the issuer shall not take into account a cost reduction in a qualified health plan offered through a health insurance exchange established in this state estimated to result from the provision of abortion coverage that the insurer offers and that covers the individual who enrolls for elective abortion coverage.

(b) As used in subdivision (d)(1)(B)(ii)*(a)* of this section, cost reduction estimated to result from provision of abortion coverage includes estimated cost reduction in prenatal care, delivery, and postnatal care;

(2) Require that if an enrollee is enrolling in a health insurance plan that provides coverage other than optional supplemental abortion coverage, at the same time as the enrollee is enrolling, the enrollee shall sign at the same time three (3) separate signatures:

(A) A signature for coverage for optional supplemental abortion coverage;

(B) A signature for coverage other than for optional supplemental abortion coverage; and

(C) A signature acknowledging that the enrollee has received the cost of the separate premium; and

(3)(A) Provide at the time of enrollment a notice to enrollees that specifically states the cost of the separate premium for coverage of elective abortions.

(B) The notice required under subdivision (d)(3)(A) of this section shall be distinct and apart from the notice of the cost of the premium for the portion of the health plan that provides coverage other than optional supplemental abortion coverage.

(e) An issuer of a health plan providing coverage offered through a health insurance exchange established in this state that provides coverage other than elective abortion coverage shall not discount or reduce the premium for the coverage on the basis that an enrollee has elective abortion coverage.

(f) This section does not apply in circumstances in which federal law preempts state health insurance regulation.

History. Acts 2013, No. 72, § 1.

23-79-157. Payment for services rendered by physical therapists, occupational therapists, and speech-language pathologists.

(a) As used in this section:

(1)(A) "Health benefit plan" means any group or blanket plan, policy, or contract for health care services issued or delivered in this state by health care insurers, including indemnity and managed care plans and the plans providing health benefits to state and public school employees under § 21-5-401 et seq., but excluding individual major medical plans and plans providing health care services under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.

(B) "Health benefit plan" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy;

(2) "Health care insurer" means any insurance company, hospital and medical service corporation, or health maintenance organization issuing or delivering health benefit plans in this state and subject to any of the following laws:

(A) The insurance laws of this state;

(B) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; and

(C) Section 23-76-101 et seq., pertaining to health maintenance organizations;

(3) "Licensed physical therapist, occupational therapist, or speech-language pathologist" means:

(A) A physical therapist licensed under §§ 17-93-101 — 17-93-312;

(B) An occupational therapist licensed under the Arkansas Occupational Therapy Practice Act, § 17-88-101 et seq.; and

(C) A speech-language pathologist licensed under §§ 17-100-102 — 17-100-308; and

(4) "Licensed primary care physician or osteopath" means a primary care physician and an osteopath licensed under §§ 17-80-101 — 17-95-505.

(b) An insurer shall not impose a copayment, coinsurance, or an office visit deductible amount or a combination of a copayment, coinsurance, or an office visit deductible amount charged to the insured for services rendered for a date of service by a licensed physical therapist, occupational therapist, or speech-language pathologist that is greater than the copayment, coinsurance, or office visit deductible amount charged to the insured for an office visit for the service of a licensed primary care physician or osteopath.

(c) An insurer shall state in its health benefit plan:

(1) The availability of physical therapy, occupational therapy, or speech-language pathologist coverage under its plan; and

(2) All related limitations, conditions, and exclusions.

History. Acts 2013, No. 342, § 1.

23-79-158. Denials of dental claims.

(a)(1) As used in this section, "insurer" means an insurance company, a health maintenance organization, a hospital and medical service corporation, or a self-insured health plan for employees of a governmental entity that provides dental benefits.

(2) As used in this section, "insurer" includes an outside review entity that contracts with an insurance company, a health maintenance organization, a hospital and medical service corporation, or a self-insured health plan for employees of a governmental entity that provides dental benefits.

(b) A denial of all or part of a dental claim based upon medical necessity shall be made by a dentist licensed in the United States who is a graduate of a Commission on Dental Accreditation accredited program.

(c) To facilitate expeditious resolution, the insurer shall provide, upon request, a written communication to the treating dentist with the name, state where licensed, license number, and direct telephone number of the reviewing dentist.

History. Acts 2013, No. 427, § 1.

23-79-159. Notification of drug formulary changes. [Effective January 1, 2014.]

(a)(1) A health benefit plan that provides prescription drug coverage or contracts with a third party for prescription drug services with tiered copayments shall notify an enrollee presently taking a prescription drug, in writing or electronically at the request of the enrollee, at least sixty (60) days before an increase in the enrollee's financial responsi-

bility as a result of a modification by the health benefit plan to the health benefit plan's drug formulary.

(2) Subdivision (a)(1) of this section does not apply to a generic substitution for a prescription drug.

(b) This section does not apply to coverage for a drug that is determined by a pharmacy and a therapeutics committee to be subject to new safety warnings.

History. Acts 2013, No. 1260, § 1.

Effective Dates. Acts 2013, No. 1260, § 2: Jan. 1, 2014. Effective date clause provided: "Section 1 of this act is effective on and after January 1, 2014."

Subchapter 2 — Suits Against Insurers

23-79-202. Limitation of actions.

RESEARCH REFERENCES

ALR. What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer. 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy. 116 A.L.R.5th 247.

CASE NOTES

Analysis

Construction.
Applicability.
Accrual of Cause of Action.

Construction.

This section's reference to "period prescribed by law for bringing actions on promises in writing" does not incorporate the judicial rule of law that generally permits insurers to shorten the period for bringing actions under insurance policies to a reasonable time. Graham v. Hartford Life & Accident Ins. Co., 677 F.3d 801 (8th Cir. 2012).

Applicability.

Insured's breach of contract suit, which was brought outside an accidental death and dismemberment policy's three-year time limit, was timely; this section precluded the insurer from contractually shortening the limitations period to less than the five-year period for breach of contract actions under § 16-56-111(a). Graham v. Hartford Life & Accident Ins. Co., 677 F.3d 801 (8th Cir. 2012).

Accrual of Cause of Action.

Insured's declaratory relief action to determine the availability of underinsured motorist benefits was an action to recover a claim arising under a policy of insurance and was governed by the five-year statute of limitation in § 16-56-111; in addition, the running of the statute of limitation was triggered by the breach of the contract and not the underlying accident. Shelter Mut. Ins. Co. v. Nash, 357 Ark. 581, 184 S.W.3d 425 (2004).

23-79-204. Venue.

CASE NOTES

Declaratory Judgment.

This section applied, by its plain terms, to actions brought by an insured and did not apply to an insurer's declaratory judgment action brought against the insured. Farm Bureau Mut. Ins. Co. of Ark. v. Gadbury-Swift, 2010 Ark. 6, 362 S.W.3d 291 (2010).

23-79-208. Damages and attorney's fees on loss claims.

(a)(1) In all cases in which loss occurs and the cargo, property, marine, casualty, fidelity, surety, cyclone, tornado, life, accident and health, medical, hospital, or surgical benefit insurance company and fraternal benefit society or farmers' mutual aid association or company liable therefor shall fail to pay the losses within the time specified in the policy after demand is made, the person, firm, corporation, or association shall be liable to pay the holder of the policy or his or her assigns, in addition to the amount of the loss, twelve percent (12%) damages upon the amount of the loss, together with all reasonable attorney's fees for the prosecution and collection of the loss.

(2) In no event will the holder of the policy or his or her assigns be liable for the attorney's fees incurred by the insurance company, fraternal benefit society, or farmers' mutual aid association in the defense of a case in which the insurer is found not liable for the loss.

(b) When attorney's fees are due a policyholder or his or her assigns, they shall be taxed by the court where the same is heard on original action, by appeal or otherwise, and shall be taxed up as a part of the costs therein and collected as other costs are or may be by law collected.

(c) Writs of attachment or garnishment filed or issued after proof of loss or death has been received by the company shall not defeat the provisions of this section, provided that the company or association desiring to pay the amount of the claim as shown in the proof of loss or death may pay the amount into the registry of the court, after issuance of writs of attachment and garnishment, in which event there shall be no further liability on the part of the company.

(d)(1) Recovery of less than the amount demanded by the person entitled to recover under the policy shall not defeat the right to the twelve percent (12%) damages and attorney's fees provided for in this section if the amount recovered for the loss is within twenty percent (20%) of the amount demanded or which is sought in the suit.

(2) Notwithstanding the provisions of subdivision (d)(1) of this section, in all cases involving a homeowner's policy, the right to reasonable attorney's fees provided for in this section shall arise if the amount recovered for the loss is within thirty percent (30%) of the amount demanded or which is sought in the suit.

(e)(1) Notwithstanding the foregoing provisions of subsections (a)-(d) of this section, this section is not intended to either vitiate or supplant the provisions of the Arkansas Rules of Civil Procedure. Those rules

and the relief described therein remain available to any litigant under the circumstances described in this section.

(2) Nothing in this section is intended to supersede, supplant, or in any way affect the rights and remedies under applicable law currently available to the insurance company, fraternal benefit society, or farmers' mutual aid association or company against policyholders who file fraudulent claims.

History. Acts 1959, No. 148, § 305; 1965, No. 437, § 1; A.S.A. 1947, § 66-3238; Acts 1991, No. 349, § 1; 1999, No. 135, § 1; 2001, No. 1604, §§ 112, 113; 2007, No. 687, § 1.

RESEARCH REFERENCES

ALR. What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer. 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy. 116 A.L.R.5th 247.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: risks, causes, and extent of loss, injury, disability, or death. 123 A.L.R.5th 259.

Validity, Construction, and Application of State Vexatious Litigant Statutes. 45 A.L.R.6th 493.

CASE NOTES

Analysis

Purpose.
Applicability.
Amount.
Award Improper.
Confession of Judgment.
Costs.
Defense or Justification.
Insurer's Liability.
Liability.
Penalty.
Penalty and Attorney's Fees.

Purpose.

Courts interpret the statute as providing that in the event an insurer wrongfully refuses to pay benefits under an insurance policy, the insured may recover the overdue benefits, 12 percent damages upon the amount of the loss, and reasonable attorney fees. The purpose of the statute is to punish the unwarranted delaying tactics of insurance companies. State Farm Fire & Cas. Co. v. Andrews, 363 Ark. 67, 210 S.W.3d 896 (2005).

Applicability.

District court properly ruled that appellant was entitled to prejudgment interest and certain costs, but that appellant was not entitled to attorneys' fees or the 12 percent penalty because it had failed to meet the requirements of this section, which authorized fees and penalties in insurance cases. Southern Pine Helicopters, Inc. v. Phoenix Aviation Managers, Inc., 358 F.3d 1086 (8th Cir. 2004).

Where life insurance company was faced with legitimate claims from both the widow and the former wife, who was still the named beneficiary, the protection offered by § 23-79-125(b) was not available because payment to the widow would not have discharged it from having to pay a claim from the former wife. Primerica Life Ins. Co. v. Watson, 362 Ark. 54, 207 S.W.3d 443 (2005).

Trial court's award of 12 percent penalty against insurer was warranted when injured driver was forced to file suit against her own insurer after she had demanded payment. Nationwide Mut. Ins.

Co. v. Cumbie, 92 Ark. App. 448, 215 S.W.3d 694 (2005).

Insured, who successfully sued an insurance company after it refused to pay her claim under a property insurance policy covering her former marital residence, could not recover attorneys fees from her ex-husband pursuant to subdivision (a)(1) of this section and § 23-79-209(a), because those statutes allowed recovery of attorney fees only from insurance companies: (1) the ex-husband waited until after a judgment was entered against the insurance company to intervene in the insured's wrongful failure to pay suit; (2) there was no legal precedent allowing the insured to collect attorney fees from her ex-husband; and (3) even if the court could award such fees it would not because both the insured and the ex-husband should bear their own fees, having chosen to fight for their own shares of the policy proceeds. Tweedle v. State Farm Fire & Cas. Co., — F. Supp. 2d —, 2008 U.S. Dist. LEXIS 63324 (E.D. Ark. July 22, 2008).

Amount.

Trial court did not err in awarding attorney fees to an insured under subdivision (a)(1) of this section based on a percentage of its recovery against an insurer under a crop insurance policy where there was no indication in the trial court's decision that the existence of a contingency-fee agreement dominated over the other reasonableness factors. Running M Farms, Inc. v. Farm Bureau Mut. Ins. Co. of Ark., 371 Ark. 308, 265 S.W.3d 740 (2007).

In insurance cases involving this section, the attorney fee awarded should not exceed the amount that the client is responsible for paying, otherwise the statute will be susceptible to abuse. Running M Farms, Inc. v. Farm Bureau Mut. Ins. Co. of Ark., 371 Ark. 308, 265 S.W.3d 740 (2007).

Award Improper.

Fact that the amount awarded in a dispute over insurance proceeds after a fire was within 20 percent of the amount demanded by insured was of no significance because the amount awarded was the exact amount tendered by insurer and rejected; therefore, an award of attorney's fees under this section was improper. State Farm Fire & Cas. Co. v. Andrews, 363 Ark. 67, 210 S.W.3d 896 (2005).

Trial court erred in awarding attorney fees and penalties to an insured under § 23-79-208(a)(1) in an action to recover the full amount of a homeowner's policy where the insurer did not wrongfully refuse to pay the claim or engage in unwarranted delaying tactics. The only disputed issue was the amount of the claim. State Farm Fire & Cas. Co. v. Andrews, 363 Ark. 67, 210 S.W.3d 896 (2005).

Confession of Judgment.

Attorney's fee and penalty attach if the insured is required to file suit, even though judgment is confessed before trial. Farm Bureau Ins. Co. of Ark., Inc. v. Running M Farms, Inc., 366 Ark. 480, 237 S.W.3d 32 (June 1, 2006).

Costs.

Under this section, if successful on her claim, the insured was entitled to her gross monthly benefit of $2,197.15 for a period of 25 months, four months of which had previously been paid by the insurer; thus, an award was proper even though no specific amount was set forth in the complaint, and the fact that the amount of benefits may be ultimately subject to offsets did not preclude recovery. Unum Life Ins. Co. of Am. v. Edwards, 362 Ark. 624, 210 S.W.3d 84 (2005).

Defense or Justification.

Trial court erred in assessing a penalty and attorney's fees against life insurance company pursuant because it had not engage in unwarranted delaying tactics; it stood ready to pay the claim but was faced with legitimate claims from both the widow and the former wife, who was still the named beneficiary, and it was for the court to decide who was the beneficiary. Primerica Life Ins. Co. v. Watson, 362 Ark. 54, 207 S.W.3d 443 (2005).

Good faith denial of liability is no defense to a claim for attorney's fee and penalty under subdivision (a)(1) of this section. Farm Bureau Ins. Co. of Ark., Inc. v. Running M Farms, Inc., 366 Ark. 480, 237 S.W.3d 32 (June 1, 2006).

Insurer's Liability.

Pursuant to subdivision (a)(1) of this section, an insurer's filing of an interpleader complaint was unreasonable where none of the named defendants had

any claim to the proceeds of the insurance policy that the insureds had filed a claim for, based on a fire that destroyed their home and personal property; a second mortgage was immaterial where the terms of the policy between the insureds and the insurer did not name the second mortgagee as a loss payee. Farm Bureau Mut. Ins. Co. of Ark., Inc. v. Guyer, 2011 Ark. App. 710, — S.W.3d — (2011).

Pursuant to subdivision (a)(1) of this section, an insurer's filing of an interpleader complaint was unreasonable where none of the named defendants had any claim to the proceeds of the insurance policy that the insureds had filed a claim for, based on a fire that destroyed their home and personal property; judgment creditors' liens did not apply to the insurance proceeds. Farm Bureau Mut. Ins. Co. of Ark., Inc. v. Guyer, 2011 Ark. App. 710, — S.W.3d — (2011).

Liability.

There was sufficient connection between the indemnity dispute and the State of Arkansas to support the application of subdivision (a)(1) of this section as to attorney's fees and penalties because defendant insurer's insurance policy matured in Arkansas, the injury to plaintiff farmers' crop caused by the insured manufacturer's product occurred in Arkansas, the damaged property was owned by Arkansas farmers, and the farmers brought suit and obtained a judgment in Arkansas against the manufacturer. Ferrell v. W. Bend Mut. Ins. Co., 393 F.3d 786 (8th Cir. 2005).

Penalty.

Insured was entitled to recover the entire 12% penalty paid by an insurance company under subdivision (a)(1) of this section and did not have to split the penalty with her ex-husband, even though it was marital property, because the insured had acted alone in filing a wrongful failure to pay suit against the company. The ex-husband was not entitled to share the penalty because he had waited until after the insured obtained a judgment against the company to intervene in the suit. Tweedle v. State Farm Fire & Cas. Co., — F. Supp. 2d —, 2008 U.S. Dist. LEXIS 63324 (E.D. Ark. July 22, 2008).

Penalty and Attorney's Fees.

Trial court did not err in granting an insured's motion for attorney fees pursuant to § 23-79-209 because the insured prevailed against the insurer's counterclaim for declaratory judgment attempting to void its obligations to pay underinsured motorist (UIM) coverage, which triggered § 23-79-209, and when the insured prevailed on her claim seeking payments under the UIM provision of her automobile liability policy that implicated this section; the application of either this section or § 23-79-209 does not necessarily preclude the application of the other if both causes of action are at issue. S. Farm Bureau Cas. Ins. Co. v. Krouse, 2010 Ark. App. 493, — S.W.3d — (2010).

Cited: State Auto Prop. Cas. Ins. Co. v. Ark. Dep't of Envtl. Quality, 370 Ark. 251, 258 S.W.3d 736 (2007); Southern Farm Bureau Cas. Ins. Co. v. Watkins, 2011 Ark. App. 388, — S.W.3d — (2011).

23-79-209. Allowance of attorney's fees in suits to terminate, modify, or reinstate policy.

CASE NOTES

Analysis

Applicability.
Attorney's Fees.
Declaratory Judgment.

Applicability.

Insured, who successfully sued an insurance company after it refused to pay her claim under a property insurance policy covering her former marital residence, could not recover attorneys fees from her ex-husband pursuant to § 23-79-208(a)(1) and subsection (a) of this section, because those statutes allowed recovery of attorney fees only from insurance companies: (1) the ex-husband waited until after a judgment was entered against the insurance company to intervene in the insured's wrongful failure to pay suit; (2) there was no legal precedent allowing the insured to collect attorney fees from her ex-husband; and (3) even if the court could award such fees it would

not because both the insured and the ex-husband should bear their own fees, having chosen to fight for their own shares of the policy proceeds. Tweedle v. State Farm Fire & Cas. Co., — F. Supp. 2d —, 2008 U.S. Dist. LEXIS 63324 (E.D. Ark. July 22, 2008).

Attorney's Fees.

Trial court did not err in granting an insured's motion for attorney fees pursuant to this section because the insured prevailed against the insurer's counterclaim for declaratory judgment attempting to void its obligations to pay underinsured motorist (UIM) coverage, which triggered this section, and when the insured prevailed on her claim seeking payments under the UIM provision of her automobile liability policy that implicated § 23-79-208; the application of either § 23-79-208 or this section does not necessarily preclude the application of the other if both causes of action are at issue. S. Farm Bureau Cas. Ins. Co. v. Krouse, 2010 Ark. App. 493, — S.W.3d — (2010).

Trial court did not abuse its discretion in granting an insured's motion for attorney fees pursuant to this section and in awarding her $22,162 because the trial court considered all the appropriate factors, and the insured's request was substantiated with billing documents and affidavits of other practicing attorneys; the trial court weighed the value of services rendered in light of the fee request, which discounted the hourly rate and removed thousands of dollars in fees. It found that inaccuracies in the time records would not significantly alter the overall finding of reasonableness. S. Farm Bureau Cas. Ins. Co. v. Krouse, 2010 Ark. App. 493, — S.W.3d — (2010).

Trial court did not err in granting an insured's motion for attorney fees pursuant to this section because it could not be reasonably argued that the insurer was not a liability insurance company, inasmuch as it issued the insured's automobile liability insurance policy, and it was the underinsured motorist section of the liability insurance policy that the insurer placed in issue by its counterclaim for a declaratory judgment; casualty insurance is part and parcel of liability insurance, and it is required to be offered to the insured as part of its liability insurance. S. Farm Bureau Cas. Ins. Co. v. Krouse, 2010 Ark. App. 493, — S.W.3d — (2010).

Declaratory Judgment.

Where an insurance policy excluded coverage for underground damage to a gas well and the underlying action against insured alleged both underground and surface damage, insured was not entitled to attorney fees for defending insurer's declaratory judgment action since insured provided no evidence of surface damage within the policy's coverage, even though the mere allegation of surface damage triggered insured's duty to defend in the underlying action. Bituminous Cas. Corp. v. Zadeck Energy Group, Inc., 416 F. Supp. 2d 654 (W.D. Ark. 2005).

Cited: Medical Liab. Mut. Ins. Co. v. Alan Curtis Enters., 373 Ark. 525, 285 S.W.3d 233 (2008).

23-79-210. Direct cause of action against liability insurer when insured not subject to tort suit.

(a)(1) When liability insurance is carried by any cooperative nonprofit corporation, association, or organization, or by any municipality, agency, or subdivision of a municipality, or of the state, or by any improvement district or school district, or by any other organization or association of any kind or character and not subject to suit for tort, and if any person, firm, or corporation suffers injury or damage to person or property on account of the negligence or wrongful conduct of the organization, association, municipality, or subdivision, its servants, agents, or employees acting within the scope of their employment or agency, then the person, firm, or corporation so injured or damaged shall have a direct cause of action against the insurer with which the liability insurance is carried to the extent of the amounts provided for

in the insurance policy as would ordinarily be paid under the terms of the policy.

(2) Any self-insurance fund, pooled liability fund, or similar fund maintained by a medical care provider for the payment or indemnification of the medical care provider's liabilities for medical injuries under § 16-114-201 et seq. shall be deemed to be liability insurance susceptible to direct action under this section.

(3) The insurer shall be directly liable to the injured person, firm, or corporation for damages to the extent of the coverage in the liability insurance policy, and the plaintiff may proceed directly against the insurer regardless of the fact that the actual tortfeasor may not be sued under the laws of the state.

(b) Any of the organizations or entities not subject to suit for tort described in subsection (a) of this section and the officers of those organizations or entities upon the request of any person so injured or damaged shall disclose the existence of any liability insurance, the name of the insurer, and the terms, amounts, and limits provided by the policy or policies.

(c)(1) Nothing in this section shall be deemed to require the organization or entity not subject to suit for tort to carry liability insurance. This section provides only for a direct action against the insurer by the injured or damaged person in the event liability insurance is so carried.

(2) The substance of this section shall by operation of law be a part of any liability insurance policy so carried, notwithstanding the terms of the policy itself, and any limitation in any policy restricting the right to recover to a judgment's first being obtained against a tortfeasor shall be void.

History. Acts 1959, No. 148, §§ 307-309; A.S.A. 1947, §§ 66-3240 — 66-3242; 2007, No. 750, § 1.

A.C.R.C. Notes. Acts 2007, No. 750, § 2, provided: "Nothing in this act confers any regulatory authority that did not exist prior to the effective date of this act upon any governmental agency over any self-insurance fund, pooled liability fund, or similar fund maintained by a medical provider."

RESEARCH REFERENCES

ALR. What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer. 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy. 116 A.L.R.5th 247.

Ark. L. Notes. Sampson, Nonprofit Risk; Nonprofit Insurance, 2008 Ark. L. Notes 83.

Ark. L. Rev. Recent Developments: Charitable-Immunity Doctrine — Direct-Action Statute, 59 Ark. L. Rev. 199.

U. Ark. Little Rock L. Rev. Annual Survey of Caselaw, Tort Law, 25 U. Ark. Little Rock L. Rev. 1041.

Annual Survey of Case Law: Tort Law, 29 U. Ark. Little Rock L. Rev. 971.

CASE NOTES

Analysis

Damages.
Direct Actions.
Evidence.
Immunity from Tort Action.
Rights of Parties.
Statute of Limitations.

Damages.

In a direct action that was brought against a liability insurer after a surgeon operated on the wrong side of the patient's brain, the circuit court did not err in reducing the jury's verdict from $20 million to $11 million. Subdivision (a)(3) of this section limited liability to the extent of coverage in the policy. Proassurance Indem. Co. v. Metheny, 2012 Ark. 461, — S.W.3d —, 2012 Ark. LEXIS 499 (Dec. 13, 2012).

Direct Actions.

In claimant's negligence action, summary judgment in favor of a hospital and health system was proper as the charitable-immunity doctrine barred recovery against the hospital, a charitable facility, the health system's pooled comprehensive liability program did not meet the statutory definition of insurance, and the health system did not meet the statutory definition of an insurer under the Arkansas Insurance Code. Sowders v. St. Joseph's Mercy Health Ctr., 368 Ark. 466, 247 S.W.3d 514 (2007), superseded by statute as stated in, Archer v. Sisters of Mercy Health Sys., 375 Ark. 523, 294 S.W.3d 414 (2009).

This section was remedial in nature and 2007 Ark. Acts 3963 (Act 750) did not create a new cause of action as the direct-action statute was a statutory remedy because it provided a new or substitute remedy for the underlying claim of negligence in cases where the plaintiff could not recover directly from a negligent charitable hospital; the amendment did not create a new legal right for injured parties, and Act 750 did not disturb any of the pooled-liability fund's vested rights. Archer v. Sisters of Mercy Health Sys., 375 Ark. 523, 294 S.W.3d 414 (2009).

Ark. R. Civ. P. 15(c) did not apply and the estate administrator's claims were barred by the statute of limitations, because the administrator's error in failing to name the insurer in the original complaint was purely due to a misunderstanding of this section, the direct-action statute, and not because she did not have the identity of the insurance company. Glass v. Saline County Med. Ctr., 2012 Ark. App. 525, — S.W.3d — (2012).

Evidence.

Where the patient filed a complaint alleging that the doctor and the medical center's nursing staff were negligent in connection with a fall she sustained, the medical center answered and pled that it was a non-profit entity insured by an insurance carrier; the carrier was named an as additional party defendant under this section, the direct-action statute. At trial, the circuit judge did not err by prohibiting the patient from presenting to the jury the fact that the medical center's insurance carrier was a named defendant; this was wholly irrelevant to the issue of the medical center's negligence. Nelson v. Stubblefield, 2009 Ark. 256, 308 S.W.3d 586 (2009), rehearing denied, — Ark. —, — S.W.3d —, 2009 Ark. LEXIS 486 (June 25, 2009).

Immunity from Tort Action.

Supreme Court of Arkansas declined to overrule *Clayborn*, which held that a nonprofit organization could be sued and found liable, but the prevailing party in the lawsuit against the nonprofit could not execute on the property or assets of the nonprofit in order to satisfy any judgment, and the direct action statute only allowed a suit against the nonprofit's insurer if the nonprofit was immune from suit, not just immune for judgment. Scamardo v. Jaggers, 356 Ark. 236, 149 S.W.3d 311 (2004), overruled, Low v. Ins. Co. of N. Am., 364 Ark. 427, 220 S.W.3d 670 (2005).

Where the scope of the charitable-immunity doctrine has undergone subtle, but significant, changes in the past century, culminating in its interpretation of the "not subject to suit for tort" language in this section as being synonymous with a charitable organization's immunity from tort liability, Scamardo v. Jaggers, 356 Ark. 236, 149 S.W.3d 311 (2004), was out of step with precedent and thereby over-

ruled; further, to the extent that Clayborn v. Bankers Standard Ins. Co., 348 Ark. 557, 75 S.W.3d 174 (2002), was inconsistent with the holding in the present case, it too was overruled. Low v. Ins. Co. of N. Am., 364 Ark. 427, 220 S.W.3d 670 (2005).

Trial court erred in denying appellants' motion to strike a medical center's amended answer in an action for medical negligence because the amended answer, in which the center stated for the first time that it was entitled to charitable immunity, was prejudicial to appellants; by the time the center filed its amended answer, any attempt to add the center's insurer as a party-defendant would have been untimely. Neal v. Sparks Reg'l Med. Ctr., 375 Ark. 46, 289 S.W.3d 8 (2008), rehearing denied, — Ark. —, — S.W.3d —, 2008 Ark. LEXIS 781 (Dec. 11, 2008).

Trial court erred in dismissing a patient's malpractice complaint against a hospital's insurer by ruling that this section, the direct-action statute, did not apply because the supreme court had held that immunity from liability in tort constituted immunity from suit under the direct-action statute and that the statute permitted a lawsuit to be filed against the insurer of a charitable organization; the patient pleaded sufficient facts in his original complaint to establish the hospital's immunity because he alleged that the hospital was a nonprofit corporation and also that the hospital was not subject to suit in tort due to the fact that it had received 26 U.S.C.S. § 501(c)(3) designation from the Internal Revenue Service. Presley v. St. Paul Fire & Marine Ins. Co., 2010 Ark. App. 367, — S.W.3d — (2010).

Rights of Parties.

Where plaintiff insurer sought to deposit its policy limits into the court, and defendants, the known claimants of an accident caused by the insured's driver's negligence, asserted counterclaims under this section, alleging the limits included additional sums, under the UIM endorsement's "Coverage" section, "underinsured motor vehicle" included a vehicle with liability coverage provided in the same policy as the UIM endorsement, and the UIM coverage was explicitly additional to any liability coverage, including the insurer's, thus, the claimants could aggregate liability and UIM coverage. Argonaut Great Cent. INS. Co. v. Casey, 701 F.3d 829, 2012 U.S. App. LEXIS 23280 (8th Cir. Nov. 13, 2012).

Statute of Limitations.

Where the Boy Scouts of America failed to inform parents and their injured child about the BSA's insurance coverage and parents failed to include insurer in the suit before the statute of limitations ran, notice was imputed to the insurer; thus, under the circumstances, the second amended complaint related back to the filing of the original complaint and was not barred by the statute of limitations. Low v. Ins. Co. of N. Am., 364 Ark. 427, 220 S.W.3d 670 (2005).

Cited: Jacobs v. Gulf Ins. Co., 85 Ark. App. 435, 156 S.W.3d 737 (2004); Downing v. Nursing Ctr., 2010 Ark. 175, — S.W.3d — (2010); Henry v. Cont'l Cas. Co., 2011 Ark. 224, — S.W.3d — (2011).

Subchapter 3 — Minimum Standards — Commercial Property and Casualty Insurance Policies

SECTION.
23-79-303. Applicability — Exceptions.

23-79-301. Purpose.

CASE NOTES

Construction with Other Law.

Where insurer sought a determination that a surplus-lines insurance policy endorsement it had issued to the insured excluded coverage for claims resulting from a shooting at the insured's private club, § 23-79-307, which required the acceptance and signature of an exclusion, was not controlling; rather, § 23-65-311(b), regarding proper delivery of the endorsement, controlled, but whether the insurer did so was immaterial because the

endorsement was ambiguous and the exclusion did not apply to assaults committed by patrons. Gawrieh v. Scottsdale Ins. Co., 83 Ark. App. 59, 117 S.W.3d 634 (2003).

23-79-303. Applicability — Exceptions.

(a) This subchapter applies to property and casualty insurance on commercial risks in this state, except:

(1) Reinsurance;

(2) Insurance against loss of or damage to aircraft or their hulls, accessories, and equipment or against liability arising out of the ownership, maintenance, or use of aircraft;

(3) Ocean marine or foreign trade insurance;

(4) Title insurance;

(5) Surety or fidelity insurance;

(6) Credit insurance;

(7) Workers' compensation or employers' liability insurance; and

(8) Large commercial risks.

(b) Sections 23-79-307(5)(A), 23-79-311, and 23-79-312 do not apply to medical malpractice insurance.

History. Acts 1987, No. 204, § 2; 1999, No. 458, § 8; 2009, No. 726, § 39.

Amendments. The 2009 amendment added (b), deleted (a)(4), redesignated the remaining subdivisions, and made related and minor stylistic changes.

23-79-306. Requirements.

CASE NOTES

In General.

Where two accounting firms merged and a claim was made against one firm after its claims-made policy expired, but before the extended reporting period lapsed, the federal district court improperly found that this section obligated the insurer to send a termination notice explaining the availability and importance of tail coverage; because it did not, the corporation could not base its breach of contract claim against the insurer on a violation of this section. Design Professionals Ins. Co. v. Chicago Ins. Co., 454 F.3d 906 (8th Cir. 2006).

23-79-307. Standards.

CASE NOTES

Construction with Other Law.

Where insurer sought a determination that a surplus-lines insurance policy endorsement it had issued to the insured excluded coverage for claims resulting from a shooting at the insured's private club, this section, which requires the acceptance and signature of an exclusion, was not controlling; rather, § 23-65-311(b), regarding proper delivery of the endorsement, controlled, but whether the insurer did so was immaterial because the endorsement was ambiguous and the exclusion did not apply to assaults committed by patrons. Gawrieh v. Scottsdale Ins. Co., 83 Ark. App. 59, 117 S.W.3d 634 (2003).

Subchapter 5 — Comprehensive Health Insurance Pool Act

A.C.R.C. Notes. Former § 23-79-514 provided: "Study of pool by interim committees.

"The Senate Interim Committee on Insurance and Commerce and the House Interim Committee on Insurance and Commerce shall conduct a study of the Arkansas Comprehensive Health Insurance Pool for the purpose of determining alternative permanent funding sources for the deficits incurred by the pool in the future."

Effective Dates. Acts 2005, No. 2036, § 29: July 1, 2005. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 2005 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 2005 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2005."

Acts 2007, No. 332, § 29: July 1, 2007. Emergency clause provided: "It is found and determined by the General Assembly, that the Constitution of the State of Arkansas prohibits the appropriation of funds for more than a two (2) year period; that the effectiveness of this Act on July 1, 2007 is essential to the operation of the agency for which the appropriations in this Act are provided, and that in the event of an extension of the Regular Session, the delay in the effective date of this Act beyond July 1, 2007 could work irreparable harm upon the proper administration and provision of essential governmental programs. Therefore, an emergency is hereby declared to exist and this Act being necessary for the immediate preservation of the public peace, health and safety shall be in full force and effect from and after July 1, 2007."

Acts 2011, No. 269, § 3: Mar. 14, 2011. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that recent changes in federal law prohibit health insurers from imposing preexisting-condition exclusions on individuals under nineteen (19) years of age; that there exists a limited market in this state of health insurers voluntarily offering individual health insurance policies to individuals under nineteen (19) years of age; that children with preexisting conditions may be unable to obtain any health insurance coverage; and that this act is immediately necessary because the lack of health insurance coverage results in the children of this state receiving inadequate medical care, foregoing wellness treatment and medical procedures, and experiencing declining health, with potentially devastating consequences to the future health and welfare of our state. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may

veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

Acts 2013, No. 713, § 3: Apr. 4, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that this act is immediately necessary because changes to the individual health insurance market beginning in 2014 eliminate the necessity of making coverage available through a state high-risk pool; that the Arkansas Comprehensive Health Insurance Pool should cease enrolling individuals on December 1, 2013, terminate all coverage under the plan at the end of the calendar day on December 31, 2013, and cease operations after efficiently winding up its business; and that planning for the cessation of operations requires immediate action by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool to transition the pool's policyholders into the commercial individual health insurance market. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-79-506. Powers.

(a)(1) The Arkansas Comprehensive Health Insurance Pool shall have the general powers and authority granted under the laws of the State of Arkansas to health insurers and, in addition thereto, the specific authority to:

(A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this subchapter;

(B) Sue or be sued, including taking any legal actions necessary or proper;

(C) Take such legal action as necessary, including without limitation:

(i) Avoiding the payment of improper claims against the pool or the coverage provided by or through the pool;

(ii) Recovering any amounts erroneously or improperly paid by the pool;

(iii) Recovering any amounts paid by the pool as a result of mistake of fact or law;

(iv) Recovering other amounts due the pool; or

(v) Coordinating legal action with the Insurance Commissioner to enforce the provisions of this subchapter;

(D)(i) Establish and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas, deductibles, copayments, coinsurance, and any other actuarial function appropriate to the operation of the pool.

(ii) Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographical variation in claim costs and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(E) Issue policies of insurance in accordance with the requirements of this subchapter. All policy forms shall be subject to the approval of the commissioner;

(F) Authorize the plan administrator to prepare and distribute certificate of eligibility forms and enrollment instruction forms to agents and to the general public;

(G) Provide and employ cost-containment measures and requirements, including without limitation preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purposes of making the plan more cost effective;

(H) Design, utilize, contract, or otherwise arrange the delivery of cost-effective health care services, including establishing or contracting directly or through the plan administrator with preferred provider organizations, health maintenance organizations, physician hospital organizations, or other limited network provider arrangements;

(I) Borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets;

(J) Pledge, assign, and grant a security interest in any of the assessments authorized by this subchapter or other assets of the pool in order to secure any notes or other evidences of indebtedness of the pool;

(K) Provide reinsurance of risks incurred by the pool;

(L) Provide additional types of plans to provide optional coverages, including Medicare supplement health insurance and health savings accounts that comply with applicable federal law as in effect January 1, 2005;

(M) Enter into reciprocal agreements with other comparable state plans in order to provide coverage for persons who move between states and are covered by such other states' plans; and

(N) Establish lifetime maximum benefits under § 23-79-510(a)(2)(W) for any person covered by a plan.

(2) In addition to the other powers granted by the Arkansas Insurance Code, the commissioner may impose, after notice and hearing in accordance with the provisions of the Arkansas Insurance Code, a monetary penalty upon any insurer or suspend or revoke the certificate of authority to transact insurance in the State of Arkansas of any insurer that fails to pay an assessment or otherwise file any report or furnish information required to be filed with the Board of Directors of the Arkansas Comprehensive Health Insurance Pool pursuant to the board's direction that the board believes is necessary in order for the board to perform its duties under this subchapter.

(b) All outstanding contracts executed by the Board of Directors of the State Comprehensive Health Insurance Pool created by Acts 1995, No. 1339, shall be deemed continuing obligations of the board created by this subchapter.

(c) As provided for in § 23-79-502, any health insurance benefit not provided for in this subchapter shall be deemed to be in conflict with and therefore inapplicable to the provisions of this subchapter.

History. Acts 1997, No. 292, § 6; 1999, No. 1356, § 2; 2005, No. 2292, § 1; 2009, No. 726, § 40.

Amendments. The 2009 amendment redesignated (a)(1) through (a)(13) as (a)(1)(A) through (a)(1)(M), inserted (a)(1)(N), redesignated (a)(14) as (a)(2), and made minor stylistic changes.

23-79-507. Funding of pool.

(a) Premiums.

(1)(A) The Arkansas Comprehensive Health Insurance Pool shall establish premium rates for plan coverage as provided in subdivision (a)(2) of this section.

(B) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(C) Premium rates and schedules shall be submitted to the Insurance Commissioner for approval prior to use.

(2)(A)(i) With the assistance of the commissioner, the pool shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals in Arkansas.

(ii) The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the coverage.

(B)(i) Rates for plan coverage shall not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard risks in Arkansas.

(ii) Subject to the limits provided in this subdivision (a)(2), subsequent rates shall be established to help provide for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this section.

(b) Sources of Additional Revenue.

(1) In addition to the powers enumerated in § 23-79-506, the pool shall have the authority to:

(A) Assess insurers in accordance with the provisions of this section; and

(B)(i) Make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses.

(ii) Any such interim assessments may be credited as offsets against any regular assessments due following the close of the fiscal year.

(2)(A) Following the close of each fiscal year, the plan administrator shall determine the net premiums, that is, premiums less administrative expense allowances, the pool expenses of administration and operation, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(B) The deficit incurred by the pool not otherwise recouped under either subdivision (b)(9) of this section or subsection (e) of this section [repealed], or both, shall be recouped by assessments apportioned among insurers by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool.

(3) Each insurer's assessment shall be determined by multiplying the total assessment of all insurers as determined in subdivision (b)(2) of this section by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums by all insurers.

(4)(A) If assessments or other funds received under either subdivision (b)(9) of this section or subsection (e) of this section [repealed], or both, or any combination of the assessments and funds exceed the pool's actual losses and administrative expenses, the excess shall be held at interest and used by the board to offset future losses or to reduce future assessments.

(B) As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(5) Each insurer's assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board or the commissioner.

(6)(A)(i) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board.

(ii) The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations.

(B)(i) In the event an assessment against an insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this subsection.

(ii) The insurer receiving the abatement or deferment shall remain liable to the plan for the deficiency for four (4) years.

(7) For all assessments issued by the board, beginning January 1, 1998, only those individuals, corporations, associations, or other entities defined as an insurer in § 23-79-503 shall be subject to assessment.

(8) In the event the board fails to act within a reasonable period of time to recoup by assessment any deficit incurred by the pool, the commissioner shall have all the powers and duties of the board under this chapter with respect to assessing insurers.

(9) The General Assembly further intends that the pool be eligible for, and for the pool, its board, or other officers of state government, as appropriate, to take steps necessary to obtain federal grant funds to offset losses of the pool, including any funds made available under the Trade Adjustment Assistance Reform Act of 2002.

(c) Assessment Offsets.

(1) Any assessment may be offset in an amount equal to the amount of the assessment paid to the pool against the premium tax payable by that insurer for the year in which the assessment is levied or for the four (4) years subsequent to that year.

(2) No offset shall be allowed for any penalty assessed under subdivision (d)(1) of this section.

(d)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of the notice by the insurer.

(2) Failure to timely pay the assessment will automatically subject the insurer to a ten percent (10%) penalty, which will be due and payable within the next thirty-day period.

(3) The board and the commissioner shall have the authority to enforce the collection of the assessment and penalty in accordance with the provisions of this subchapter and the Arkansas Insurance Code.

(4) The board may waive the penalty authorized by this subsection if it determines that compelling circumstances exist that justify such a waiver.

(e) [Repealed.]

History. Acts 1997, No. 292, § 7; 2001, No. 1246, §§ 2, 3; 2003, No. 1327, § 3; 2003, No. 1583, § 5; 2005, No. 2036, § 24; 2005, No. 2292, §§ 2, 3; 2007, No. 332, § 24; 2009, No. 726, § 41.

A.C.R.C. Notes. Pursuant to § 1-2-207, this section is set out above as amended by Acts 2005, No. 2292. Subdivision (c)(2) and subsection (e) of this section were amended by Acts 2005, No. 2036 to read as follows:

"(2) For any fiscal year in which the board determines that the pool did not incur a deficit as calculated under subdivision (b)(2) of this section, the State Insurance Department shall not transfer during the following fiscal year any funds to the pool from the State Insurance Department Trust Fund under subdivision (e)(1)(B) of this section."

"(e) Payment from the State Insurance Department Trust Fund.

"(1)(A) Following the close of each fiscal year, the board shall determine whether the pool has incurred a deficit as calculated under subdivision (b)(2) of this section.

"(B) If a deficit under subdivision (b)(2) of this section has been incurred, during the next fiscal year, the State Insurance Department shall transfer in equal quarterly installments from the State Insurance Department Trust Fund for deposit into the pool a sum equal to the deficit from those funds in the State Insurance Department Trust Fund that are in excess of the amount needed to meet the requirements of the approved annual budget for the applicable fiscal year, but not to exceed two million dollars ($2,000,000)."

Amendments. The 2009 amendment deleted (d)(2) and redesignated (d)(1)(A) through (d)(1)(D) as (d)(1) through (d)4).

23-79-509. Plan eligibility.

(a) General Eligibility Requirements. The following requirements apply to a resident eligible person or a trade adjustment assistance eligible person in order for the person to be eligible for plan coverage:

(1) Except as provided in subdivision (a)(2) of this section or subsection (b) of this section, any individual person who meets the definition of resident eligible person as defined by § 23-79-503 or a trade adjustment assistance eligible person as defined by § 23-79-503 and is

either a citizen of the United States or an alien lawfully admitted for permanent residence who continues to be a resident of this state shall be eligible for plan coverage if evidence is provided of:

(A) A notice of rejection or refusal by an insurer to issue substantially similar individual health insurance coverage by reason of the existence or history of a medical condition or upon such other evidence that the Board of Directors of the Arkansas Comprehensive Health Insurance Pool deems sufficient in order to verify that the applicant is unable to obtain the coverage from an insurer due to the existence or history of a medical condition;

(B)(i) A refusal by an insurer to issue individual health insurance coverage except at a rate that the board determines is substantially in excess of the applicable plan rate.

(ii) A rejection or refusal by a group health plan or insurer offering only stop-loss or excess-of-loss insurance or contracts, agreements, or other arrangements for reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;

(C)(i) Until September 30, 2011, a refusal by an insurer to issue individual health insurance coverage to a child under nineteen (19) years of age.

(ii) After September 30, 2011, the eligibility of a child under nineteen (19) years of age for individual health insurance coverage shall be determined by the board; or

(D) Evidence that the applicant was covered under a qualified high risk pool of another state, provided that the coverage terminated no more than sixty-three (63) days prior to the date the pool receives the applicant's application for coverage and the other state's qualified high risk pool did not terminate the person's coverage for fraud;

(2) A person shall not be eligible for coverage under the plan if:

(A) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it except that:

(i) A person may maintain other coverage for the period of time the person is satisfying any waiting period for a preexisting condition under a plan policy; and

(ii) A person may maintain plan coverage for the period of time the person is satisfying a waiting period for a preexisting condition under another health insurance policy intended to replace the plan policy;

(B) The person is determined to be eligible for health care benefits under Title XIX of the Social Security Act;

(C) The person has previously terminated plan coverage unless twelve (12) months have elapsed since termination of coverage;

(D) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the plan shall be limited to benefits incurred under the plan for the same period for which premiums had been paid and the covered person remained eligible for plan coverage;

(E) The plan has paid on behalf of the covered person the maximum lifetime benefit established by the board in accordance with § 23-79-510(a)(2)(W);

(F) The person is a resident of a public institution;

(G) All or part of the person's premium is paid for or reimbursed:

(i) By one (1) of the following in connection with a group health plan:

(a) The person's current employer;

(b) If the person is retired, by the person's former employer; or

(c) If the person is a dependent of an employee or retiree, by the current or former employer of the employee or retiree; or

(ii) Under any government-sponsored program or by any government agency, foundation, health care facility, or health care provider except for premiums paid on behalf of:

(a) A trade adjustment assistance eligible person or a qualified trade adjustment assistance eligible person in accordance with section 35 of the Internal Revenue Code; or

(b) An otherwise qualifying full-time employee or dependent of a qualifying full-time employee of a government agency, foundation, health care facility, or health care provider; or

(H) The person commits a fraudulent insurance act as defined in § 23-66-501(4) against the Arkansas Comprehensive Health Insurance Pool;

(3) The board or the plan administrator shall require verification of residency and may require any additional information, documentation, or statements under oath whenever necessary to determine plan eligibility or residency;

(4) Coverage shall cease:

(A) On the date a person is no longer a resident of the State of Arkansas;

(B) On the date a person requests coverage to end;

(C) On the death of the covered person;

(D) On the date state law requires cancellation of the policy; or

(E) At the plan's option, thirty (30) days after the plan makes any written inquiry concerning a person's eligibility or place of residence to which the person does not reply; and

(5) Except under the conditions set forth in subdivision (a)(4) of this section, the coverage of any person who ceases to meet the eligibility requirements of this section terminates at the end of the month that the person ceases to meet the eligibility requirements of this section.

(b) Persons Eligible for Guaranteed Issuance of Coverage. The following requirements apply to a federally eligible individual or a qualified trade adjustment assistance eligible person in order for such an individual to be eligible for plan coverage:

(1) Notwithstanding the requirements of subsection (a) of this section, any federally eligible individual or a qualified trade adjustment assistance eligible person for whom a plan application and such enclosures and supporting documentation as the board may require is

received by the board within sixty-three (63) days after the termination of prior creditable coverage for reasons other than nonpayment of premium or fraud that covered the applicant shall qualify to enroll in the plan under the portability provisions of this subsection;

(2) Any individual seeking plan coverage under this subsection must submit with his or her application evidence, including acceptable written certification of previous creditable coverage, that will establish to the board's satisfaction that he or she meets all of the requirements to be a federally eligible individual or a qualified trade adjustment assistance eligible person and is currently and permanently residing in the State of Arkansas as of the date his or her application was received by the board;

(3) A period of creditable coverage shall not be counted, with respect to qualifying an applicant for plan coverage as an individual under this subsection, if after such a period and before the application for plan coverage was received by the board, there was at least a sixty-three-day period during all of which the individual was not covered under any creditable coverage;

(4) Any individual who the board determines qualifies for plan coverage under this subsection shall be offered his or her choice of enrolling in one (1) of the alternative portability plans that the board is authorized under this subsection to establish for those individuals;

(5)(A)(i) The board shall offer a choice of health-care coverages consistent with major medical coverage under the alternative plans authorized by this subsection to every individual qualifying for coverage under this subsection.

(ii) The coverages to be offered under the plans, the schedule of benefits, deductibles, copayments, coinsurance, exclusions, and other limitations shall be approved by the board.

(B) One (1) optional form of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in the State of Arkansas or a standard option of coverage available under the individual health insurance laws of the State of Arkansas. The standard plan that is authorized by § 23-79-510 may be used for this purpose.

(C) The board also may offer a preferred provider option and such other options as the board determines may be appropriate for individuals who qualify for plan coverage pursuant to this subsection;

(6) Notwithstanding the requirements of § 23-79-510(f), any plan coverage that is issued to individuals who qualify for plan coverage pursuant to the portability provisions of this subsection shall not be subject to any preexisting conditions exclusion, waiting period, or other similar limitation on coverage;

(7) Individuals who qualify and enroll in the plan pursuant to this subsection shall be required to pay such premium rates as the board shall establish and approve in accordance with the requirements of § 23-79-507(a);

(8) The total premium, without regard to any subsidy of premium, for individuals who qualify and enroll in the plan pursuant to this

subsection shall not be greater than a similarly situated individual qualifying for pool coverage under subsection (a) of this section; and

(9) A federally eligible individual who qualifies and enrolls in the plan pursuant to this subsection must continue to satisfy all of the other eligibility requirements of this subchapter to the extent not inconsistent with the Health Insurance Portability and Accountability Act of 1996 in order to maintain continued eligibility for coverage under the plan.

(c) Any person who was issued a policy pursuant to the provisions of Acts 1995, No. 1339, shall be deemed continuously covered consistent with the terms of this subchapter and reissued a new policy in accordance with the provisions of this subchapter.

History. Acts 1997, No. 292, § 9; 1999, No. 1356, § 3; 2001, No. 1246, § 4; 2003, No. 1327, § 4; 2009, No. 726, §§ 42, 43; 2009, No. 1452, § 2; 2011, No. 269, § 2.

A.C.R.C. Notes. Acts 2011, No. 269, § 1, provided: "Health insurance for individuals under nineteen years of age.

"(a) As used in this act:

"(1)(A) 'Child-only plan' means renewable individual health insurance for a qualified individual other than excepted benefits as defined in § 23-86-310.

"(B) 'Child-only plan' does not include dependent health insurance for a qualified individual under another person's health insurance;

"(2)(A) 'Health insurance' means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise and includes any excess or stop-loss coverage.

"(B) 'Health insurance' does not include long-term care, disability income, short-term, accident, dental-only, vision-only, fixed indemnity, limited-benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

"(3) 'Individual health insurance' means health insurance offered to individuals in the individual market but does not include short-term limited duration insurance;

"(4)(A) 'Insurer' means any entity that provides health insurance, including excess or stop-loss health insurance, in the State of Arkansas.

"(B) 'Insurer' includes an insurance company, medical services plans, hospital plans, hospital medical service corporations, health maintenance organizations, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

"(5) 'Open enrollment period' means October 1 through October 31 annually, beginning October 1, 2011;

"(6) 'Qualifying event' means the loss of employer-sponsored health insurance or the involuntary loss of other existing health insurance for any reason other than fraud, misrepresentation, or failure to pay a premium if the applicant is a qualified individual when the qualifying event occurs; and

"(7)(A) 'Qualified individual' means a resident of this state under nineteen (19) years of age.

"(B) 'Qualified individual' does not include a person who is not a United States citizen or who is present in the United States illegally.

"(b)(1) An insurer shall establish and administer the open enrollment period for the purpose of offering a child-only plan to each qualified individual.

"(2) During the open enrollment period and within thirty (30) days of a qualifying event, an insurer shall accept and grant an application to insure a qualified individual for a child-only plan on a guaranteed-issue basis without any limitations

or exclusions of policy benefits based upon the applicant's health status.

"(c)(1) Until the end of the initial open enrollment period, the Arkansas Comprehensive Health Insurance Pool shall provide health insurance to qualified individuals under § 23-79-509(a)(1)(C).

"(2) At the end of the initial open enrollment period, the eligibility of a qualified individual for health insurance under the Arkansas Comprehensive Health Insurance Pool shall be determined under policies and procedures established by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool.

"(d) The Insurance Commissioner shall adopt rules to implement and administer this act.

"(e) This act and the rules adopted by the commissioner to administer this act expires on January 1, 2014."

Amendments. The 2009 amendment by No. 726, in (a), rewrote (a)(2)(E), inserted (a)(2)(H), substituted "month that the person ceases to meet the eligibility requirements of this section" for "current policy period for which the necessary premiums have been paid" in (a)(5), and made related and minor stylistic changes.

The 2009 amendment by No. 1452, in (a)(2)(G), inserted (a)(2)(G)(i), redesignated the existing text accordingly, inserted "All or part of" in the introductory language, and made related changes.

The 2011 amendment inserted present (a)(1)(C) and redesignated former (a)(1)(C) as (a)(1)(D).

23-79-510. Outline of benefits.

(a)(1) Subject to the contractual policy form language adopted by the Board of Directors of the Arkansas Comprehensive Health Insurance Pool, expenses for the following services, supplies, drugs, or articles when prescribed by a physician and determined by the plan to be medically necessary shall be covered, subject to provisions of subsection (b) of this section:

(A) Hospital services;

(B) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, that are rendered by a physician or by other licensed professionals at his or her direction;

(C) Drugs requiring a physician's prescription;

(D) Skilled nursing services of a licensed skilled nursing facility for not more than one hundred twenty (120) days during a policy year;

(E) Services of a home health agency up to a maximum of two hundred seventy (270) services per year;

(F) Use of radium or other radioactive materials;

(G) Oxygen;

(H) Prostheses other than dental;

(I) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which such equipment is prescribed;

(J) Diagnostic X rays and laboratory tests;

(K) Oral surgery for excision of partially or completed unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(L) Services of a physical therapist;

(M) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest facility qualified to treat a covered condition;

(N) Services for diagnosis and treatment of mental and nervous disorders or chemical and drug dependency, provided that a covered person shall be required to make a fifty percent (50%) copayment and that the plan's payment shall not exceed four thousand dollars ($4,000) annually; and

(O) Such additional benefits deemed appropriate by the board in accordance with the provisions of subsection (b) of this section.

(2) Exclusions. Unless the contractual policy form language adopted by the board provides otherwise, the following services, supplies, drugs, or articles whether or not prescribed by a physician shall not be covered:

(A) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;

(B) Care that is primarily for custodial or domiciliary purposes;

(C) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless a private room is medically necessary;

(D) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel that exceeds the prevailing charge in the locality or for any charge not medically necessary;

(E) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;

(F) Any expense incurred prior to the effective date of coverage by the plan for the person on whose behalf the expense is incurred;

(G) Dental care except as provided in subdivision (a)(1)(K) of this section;

(H) Eyeglasses and hearing aids;

(I) Illness or injury due to acts of war;

(J) Services of blood donors and any fee for failure to replace the first three (3) pints of blood provided to a covered person each policy year;

(K) Personal supplies or services provided by a hospital or nursing home or any other nonmedical or nonprescribed supply or service;

(L) Any expense or charge for services, articles, drugs, or supplies that are not provided in accord with generally accepted standards of current medical practice;

(M) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay;

(N) Any expense incurred for benefits provided under the laws of the United States and the State of Arkansas, including Medicare and Medicaid and other medical assistance, military service-connected disability payments, medical services provided for members of the armed forces and their dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States;

(O) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy;

(P) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures;

(Q) Any expense or charge for sterilization or sterilization reversals;

(R) Any expense or charge for weight-loss programs, exercise equipment, or treatment of obesity except when certified by a physician as morbid obesity, i.e., at least two (2) times normal body weight;

(S) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery;

(T) Any expense or charge for organ or bone marrow transplants other than those performed at a hospital with a board-approved organ transplant program that has been designated by the board as a preferred provider organization for that specific organ or bone marrow transplant;

(U) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical specialty college for general use within the medical community;

(V) Such additional exclusions deemed appropriate by the board in accordance with the provisions of subsection (b) of this section; and

(W)(i) Any benefits that exceed the maximum lifetime benefit for plan coverage established by the board under § 23-79-506(a)(1)(N).

(ii) The maximum lifetime benefit shall not be less than one million dollars ($1,000,000) and shall not exceed three million dollars ($3,000,000).

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and medical economic factors as may be deemed appropriate and promulgate benefits, deductibles, copayments, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles, copayments, and coinsurance factors annually according to the medical component of the Consumer Price Index for All Urban Consumers.

(d) Nonduplication of Benefits.

(1)(A) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available.

(B) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance or any other source providing benefits because of a sickness or injury and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile

medical payment, or liability insurance whether provided on the basis of fault or nonfault and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The pool shall have a cause of action against a covered person for the recovery of the amount of benefits paid that are not covered by the pool. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subdivision (d)(2).

(e) Right of Subrogation — Recoveries.

(1)(A) Whenever the pool has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence or for which an insurance company or self-insured entity is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for damages, the pool shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from the sickness or injury.

(B) The pool shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage including coverage under a workers' compensation act without the necessity of assignment of claim or other authorization to secure the right of recovery.

(C) To enforce its subrogation right, the pool may:

(i) Intervene or join in an action or proceeding brought by the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurance carrier or self-insured entity that may be liable; or

(ii) Institute and prosecute legal proceedings against any third party or the third party's insurance carrier or self-insured entity that may be liable for the sickness or injury in an appropriate court either in the name of the pool or in the name of the covered person or his or her personal representative including his or her guardian, conservator, estate, dependents, or survivors.

(2)(A)(i) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurance carrier or self-insured entity, the covered person or his or her personal representative, including his or her guardian, conservator, estate, dependents, or survivors, shall notify the pool by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim.

(ii) The pool may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection.

(B) No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the

written consent of the pool to the extent of its interest in the settlement or judgment and of the covered person or his or her personal representative.

(3)(A) In the event that the covered person or his or her personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the pool, in its own name or in the name of the covered person or personal representative, may commence a proceeding against any appropriate third party for the recovery of damages on account of any sickness, injury, or death to the covered person.

(B) The covered person shall cooperate in doing what is reasonably necessary to assist the pool in any recovery and shall not take any action that would prejudice the pool's right to recovery.

(C) The pool shall pay to the covered person or his or her personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the pool and amounts paid or to be paid as costs, attorney's fees, and reasonable expenses incurred by the pool in making the collection or enforcing the judgment.

(4)(A)(i) In the event of judgment or award in either a suit or claim against a third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees.

(ii) After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the pool the full amount of benefits paid on behalf of the covered person under this subchapter, provided that the court may reduce and apportion the pool's portion of the judgment proportionately to the recovery of the covered person.

(B)(i) The burden of producing sufficient evidence to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction.

(ii) The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative or contributory negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs.

(C) The pool shall pay its pro rata share of the attorney's fees based on the pool's recovery as it compares to the total judgment.

(D) Any reimbursement rights of the pool shall take priority over all other liens and charges existing under the laws of the State of Arkansas.

(5) The pool may compromise or settle and release any claim for benefits provided under this subchapter or waive any claims for benefits, in whole or in part, for the convenience of the pool or if the pool determines that collection will result in undue hardship upon the covered person.

(f) Preexisting Conditions.

(1) Except for federally eligible individuals or qualified trade adjustment assistance eligible persons qualifying for plan coverage under § 23-79-509(b) or resident eligible persons or trade adjustment assistance eligible persons who qualify for and elect to purchase the waiver authorized in subdivision (f)(2) of this section, plan coverage shall exclude charges or expenses incurred during the first six (6) months following the effective date of coverage as to any condition if:

(A) The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care, or treatment; or

(B) Medical advice, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of the coverage.

(2) Waiver. The preexisting condition exclusions as set forth in subdivision (f)(1) of this section will be waived to the extent to which the resident eligible person or trade adjustment assistance eligible person:

(A) Has satisfied similar exclusions under any prior individual health insurance coverage that was involuntarily terminated; and

(B)(i) Has applied for plan coverage not later than thirty (30) days following the involuntary termination.

(ii) For each resident eligible person or trade adjustment assistance eligible person who qualifies for and elects this waiver, there shall be added on a prorated basis to each payment of premium a surcharge of up to ten percent (10%) of the otherwise applicable annual premium for as long as that individual's coverage under the plan remains in effect or sixty (60) months, whichever is less.

(3)(A) Whenever benefits are due from the plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may recover damages from a third party or its insurance carrier or self-insured entity, the plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable in the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

(B)(i) During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurance carrier or self-insured entity, any benefits that would otherwise be payable except for the provisions of this subsection shall be paid if payment by or for the third party has not yet been made and the covered person or, if capable, that person's legal representative agrees in writing to pay back properly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury.

(ii) This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

(C) Any amounts due the plan to repay benefits may be deducted from other benefits payable by the plan after payments by or for the third party are made.

(4) Benefits due from the plan may be reduced or refused as an offset against any amount otherwise recoverable under this section.

History. Acts 1997, No. 292, § 10; 2003, No. 1327, § 5; 2009, No. 726, § 44.

Amendments. The 2009 amendment deleted (a)(2)(L) and (a)(2)(N), inserted (a)(2)(W), and redesignated the remaining subdivisions accordingly, and made related and minor stylistic changes.

CASE NOTES

Analysis

Made-Whole Doctrine.
Settlement Agreements.

Made-Whole Doctrine.

The made-whole doctrine applies to claims made under this section. Ark. Comprehensive Health Ins. Pool v. Denton, 374 Ark. 162, 286 S.W.3d 698 (2008).

Settlement Agreements.

Trial court properly determined that the Arkansas Comprehensive Health Insurance Pool was not entitled to reimbursement from an insured after the insured entered into a settlement agreement with third-party property owners because the insured was not made whole by the settlement. Ark. Comprehensive Health Ins. Pool v. Denton, 374 Ark. 162, 286 S.W.3d 698 (2008).

23-79-513. Unfair referral to plan — Prohibited practices by employers.

(a) It shall constitute an unfair trade practice under the Trade Practices Act, § 23-66-201 et seq., for an insurer, agent, broker, or third-party administrator to refer an individual to the Arkansas Comprehensive Health Insurance Pool or arrange for an individual to apply to the pool for the purpose of:

(1) Separating the individual from group health insurance coverage provided by a group health plan; or

(2) Facilitating enrollment in the pool by any of the following individuals associated with an employer, with the knowledge that the employer intends to pay or is paying all or part of the premium payments owed by the individual for pool coverage:

(A) An employee of the employer;

(B) A retired employee of the employer; or

(C) A dependent of an employee or retired employee of the employer.

(b) Because pool coverage is not intended to cover participants who are eligible for a group health plan, an individual described in subdivision (a)(2) of this section is not eligible:

(1) For pool coverage if the employer associated with the applicant intends to pay for all or part of the pool premium payments for the individual; or

(2) To continue pool coverage if the employer associated with the individual directly or indirectly pays all or part of the pool premium payments for the individual.

History. Acts 1997, No. 292, § 13; 1997, No. 1000, § 25; 2009, No. 1452, § 3.

Amendments. The 2009 amendment inserted (a)(2), redesignated the existing text accordingly, and made related and minor stylistic changes.

23-79-514. [Repealed.]

Publisher's Notes. This section, concerning the study of pool by interim committees, was repealed by Acts 2005, No. 1962, § 109. The section was derived from Acts 2003, No. 1327, § 6.

23-79-515. Orderly cessation of operations.

(a)(1) The Arkansas Comprehensive Health Insurance Pool shall cease enrollment and coverage under the plan on and after January 1, 2014, as required by federal law.

(2) After taking all reasonable steps, including those specified in this section, to timely and efficiently assist in the transition of individuals receiving plan coverage to the individual health insurance market, the Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall cease operating the pool after paying health insurance claims for plan coverage and meeting all other obligations of the board under this section.

(b) The board may take all actions it deems necessary to:

(1) Cease enrollment for plan coverage effective December 1, 2013;

(2)(A) Terminate all existing plan coverage effective at the end of the calendar day on December 31, 2013.

(B) The board shall provide at least ninety (90) days notice to current policyholders of the termination; and

(3) Amend plan policies and provide adequate notice to policyholders, agents, and providers that to be paid or reimbursed, a claim for plan services is required to be filed by the earlier of one hundred eighty (180) days after plan coverage ends or three hundred sixty-five (365) days after the date of service giving rise to the claim.

(c) This section does not require the board to revise plan benefits to comply with federal law or to maintain plan coverage for any individual after December 31, 2013.

(d)(1) After all plan coverage terminates under this section, the board shall take reasonable steps to wind up all significant operations of the pool by December 31, 2014.

(2) Notwithstanding any other provision of this subchapter, to facilitate an efficient cessation of operations:

(A) The board may continue to use existing contractors until cessation of operations without the need to issue competitive requests for proposals;

(B) The board may continue to fund operations of this subchapter under § 23-79-507;

(C) The board shall remain in effect:

(i) As provided by § 23-79-504(b); and

(ii) Until a judgment, order, or decree in any action, suit, or proceeding commenced against or by the pool is fully executed; and

(D)(i) The term of each current board member shall be extended until the date the pool concludes all business as provided under this section and the Insurance Commissioner certifies the cessations of operations under subsection (g) of this section.

(ii) The term of a board member expires when the commissioner certifies the cessations of operations under subsection (g) of this section.

(e) On or before June 30, 2013, the board shall amend the plan of operation to reflect the actions necessary to implement this section.

(f) If the board has excess funds after the cessation of operations of the pool, the funds shall be returned to the general revenue funds of the state.

(g)(1) On or before March 1, 2016, or a later date if necessary to complete the cessation of operations of the pool, the board shall file a report with the General Assembly and commissioner that reflects completion of the requirements of this section and includes an independent auditor's report on the financial statements of the pool.

(2) If satisfied upon review of the report that the board has complied with this section and accomplished the pool's cessation of operations in a reasonable manner, the commissioner shall certify that the business of the pool has concluded in accordance with this section and publish the certification on the State Insurance Department website.

(h) Upon certification under subsection (g) of this section, the operations of the pool are suspended indefinitely unless reactivated by the General Assembly.

(i) The commissioner may address any matters regarding the pool arising after the certification under subsection (g) of this section, and the Attorney General shall defend a legal action filed after the certification, including seeking the dismissal of the action under § 23-79-516 or for any other purpose.

(j) Unless inconsistent with this section, the remainder of this subchapter continues to apply to the pool and the board.

History. Acts 2013, No. 713, § 2.

A.C.R.C. Notes. Acts 2013, No. 713, § 1, provided: "Findings and legislative intent.

"(a) The General Assembly finds that:

"(1) The Arkansas Comprehensive Health Insurance Pool was created to provide health care coverage for individuals to whom comprehensive health care coverage is not available in the individual health insurance market because of preexisting health conditions; and

"(2) As of January 1, 2014, federal law provides that health insurance carriers in

the individual market cannot reject applicants for health insurance coverage based on the presence of preexisting health conditions or exclude health care coverage for preexisting conditions.

"(b) It is the intent of the General Assembly by the enactment of this act to provide for the orderly cessation of the Arkansas Comprehensive Health Insurance Pool's operations after December 31, 2013."

23-79-516. Statute of limitations and repose.

Because winding up the operations of the Arkansas Comprehensive Health Insurance Pool requires the expeditious determination of its outstanding liabilities, a cause of action against the pool or the Board of Directors of the Arkansas Comprehensive Health Insurance Pool shall be commenced within the earlier of one (1) year after the cause of action accrues or December 31, 2015.

History. Acts 2013, No. 713, § 2.

A.C.R.C. Notes. Acts 2013, No. 713, § 1, provided: "Findings and legislative intent.

"(a) The General Assembly finds that:

"(1) The Arkansas Comprehensive Health Insurance Pool was created to provide health care coverage for individuals to whom comprehensive health care coverage is not available in the individual health insurance market because of preexisting health conditions; and

"(2) As of January 1, 2014, federal law provides that health insurance carriers in the individual market cannot reject applicants for health insurance coverage based on the presence of preexisting health conditions or exclude health care coverage for preexisting conditions.

"(b) It is the intent of the General Assembly by the enactment of this act to provide for the orderly cessation of the Arkansas Comprehensive Health Insurance Pool's operations after December 31, 2013."

23-79-517. Individuals moving to Arkansas and previously covered by another qualified high-risk pool.

(a) Notwithstanding § 23-79-510(f), if a resident eligible person is eligible for plan coverage because the person previously was covered under a qualified high-risk pool of another state, a preexisting condition exclusion otherwise applicable to the resident eligible person:

(1) Shall be reduced by each month of coverage in which the resident eligible person was subject to a preexisting condition exclusion in the other state's qualified high-risk pool; or

(2) Does not apply if the resident eligible person was not subject to a preexisting condition exclusion in the other state's qualified high-risk pool.

(b) This section expires on the last day an individual may be enrolled into plan coverage under this subchapter.

History. Acts 2013, No. 713, § 2.

A.C.R.C. Notes. Acts 2013, No. 713, § 1, provided: "Findings and legislative intent.

"(a) The General Assembly finds that:

"(1) The Arkansas Comprehensive Health Insurance Pool was created to provide health care coverage for individuals to whom comprehensive health care coverage is not available in the individual

health insurance market because of preexisting health conditions; and

"(2) As of January 1, 2014, federal law provides that health insurance carriers in the individual market cannot reject applicants for health insurance coverage based on the presence of preexisting health conditions or exclude health care coverage for preexisting conditions.

"(b) It is the intent of the General Assembly by the enactment of this act to provide for the orderly cessation of the Arkansas Comprehensive Health Insurance Pool's operations after December 31, 2013."

Subchapter 9 — Arkansas Advisory Commission on Mandated Health Insurance Benefits

SECTION.

A.C.R.C. Notes. Pursuant to Acts 2007, No. 303, § 1, the entirety of § 23-79-906 was repealed even though part of § 23-79-906(b)(1)(O) was not stricken through in the act.

23-79-901 — 23-79-906. [Repealed.]

Publisher's Notes. These sections, concerning purpose, commission established — members — meetings, duties of the commission, contract services — staff assistance, submission of report, and legislative review of proposed mandated health benefit laws, were repealed by Acts 2007, No. 303, § 1. The sections were derived from the following sources:

23-79-901. Acts 2001, No. 1730, § 1.

23-79-902. Acts 2001, No. 1730, §§ 2-4; 2005, No. 1926, § 1.

23-79-903. Acts 2001, No. 1730, § 5; 2005, No. 1926, § 2.

23-79-904. Acts 2001, No. 1730, §§ 6, 7.

23-79-905. Acts 2001, No. 1730, § 8.

23-79-906. Acts 2005, No. 1926, § 3.

Subchapter 10 — Health Insurance Flexibility and Accountability Initiative

SECTION.

23-79-1001. Findings and purpose.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Legislation, 2003 Arkansas General Assembly, Insurance Law, Health Insurance, 26 U. Ark. Little Rock L. Rev. 482.

23-79-1004. Arkansas Safety-net Benefit Fund.

(a)(1) There is created the Arkansas Safety-net Benefit Fund.

(2) The fund shall be administered by the Department of Finance and Administration.

(b)(1) The fund shall not be deposited into a general revenue holding account or regulated by the State Insurance Department and shall be used only for the Arkansas Safety-net Benefit Program.

(2) However, if the federal government eliminates or substantially modifies the Health Insurance Flexibility and Accountability demonstration initiative or withdraws approval of the program, moneys remaining in the fund shall not be placed in the State Treasury but shall be expended to provide services to beneficiaries of the program.

(3) Moneys in the fund may carry over from the first fiscal year of any biennium to the second fiscal year of the biennium and from one biennium to the next.

History. Acts 2003, No. 1044, § 1; 2005, No. 1681, § 1.

Subchapter 11 — Equity in Prescription Insurance and Contraceptive Coverage Act

23-79-1101. Title.

This subchapter shall be known and may be cited as the "Equity in Prescription Insurance and Contraceptive Coverage Act".

History. Acts 2005, No. 2217, § 1.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Legislation, 2005 Arkansas General Assembly, Insurance Law, 28 U. Ark. Little Rock L. Rev. 393.

23-79-1102. Definitions.

As used in this subchapter:

(1)(A) "Health benefit policy" means an individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including those contracts executed by the State of Arkansas on behalf of state employees, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, provider-sponsored health care corporation, or other insurer or similar entity.

(B) "Health benefit policy" does not include:

(i) Accident-only, credit, specified disease, dental, hospital indemnity, Medicare supplement, long-term care, or disability income insurance policies;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Workers' compensation or similar insurance; or

(iv) Automobile medical-payment insurance;

(2) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under Title 23 of this Code; and

(3) "Religious employer" means an entity that:

(A) Is organized and operated for religious purposes and has received a section 501(c)(3) designation from the Internal Revenue Service;

(B) Has as one (1) of its primary purposes the inculcation of religious values; and

(C) Employs primarily persons who share its religious tenets.

History. Acts 2005, No. 2217, § 1.

23-79-1103. Parity for contraceptives.

(a) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Insurance Commissioner on or after August 12, 2005, that provides coverage for prescription drugs on an outpatient basis shall provide coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

(b) Nothing contained in this subchapter shall be construed to require any insurance company to provide coverage for an abortion, an abortifacient, or any United States Food and Drug Administration-approved emergency contraception.

History. Acts 2005, No. 2217, § 1.

23-79-1104. Extraordinary surcharges prohibited.

(a) No insurer shall impose upon any person receiving prescription contraceptive benefits pursuant to this subchapter any:

(1) Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level, or copayment level receiving benefits for prescription drugs; or

(2) Reduction in allowable reimbursement for prescription drug benefits.

(b) This subchapter shall not be construed to:

(1) Require coverage for prescription coverage benefits in any contract, policy, or plan that does not otherwise provide coverage for prescription drugs;

(2)(A) Preclude the use of closed formularies.

(B) However, the formularies shall include oral, implant, and injectable contraceptive drugs, intrauterine devices, and prescription barrier methods; or

(3) Require any religious employer to comply with this subchapter.

History. Acts 2005, No. 2217, § 1.

Subchapter 12 — Coverage for Colorectal Cancer Screening

Effective Dates. Acts 2005, No. 2236, § 3: Aug. 1, 2005. Emergency clause provided: "It is hereby found and determined that colorectal cancer is a leading cause of death among Arkansas residents; that this number of deaths will increase as our population grows older; that colorectal cancer is a preventable disease; that information barriers result in Arkansas residents being unaware of the risk of colorectal cancer or the value of screening, prevention, and early detection; that financial barriers prevent some Arkansas residents from taking advantage of screening; and that there is a lack of funding to provide for screening, diagnostic, and treatment services for persons at risk of colorectal cancer. Therefore, this act being necessary for the preservation of the public peace, health, and safety shall be in full force and effect from and after August 1, 2005."

23-79-1201. Definitions.

As used in this subchapter:

(1) "Covered person" means a person who is and continues to remain eligible for coverage under a health care policy and is covered under a health care policy;

(2)(A) "Health care policy" means:

(i) An individual or group health insurance policy providing coverage on an expense-incurred basis;

(ii) An individual or group service or indemnity type contract issued by a nonprofit corporation;

(iii) An individual or group service contract issued by a health maintenance organization;

(iv) A group accident and sickness insurance policy issued by a fraternal benefit society, a nonprofit hospital service corporation, a nonprofit medical service corporation, a group health care plan, a health maintenance organization, or any similar entity; and

(v) A policy issued by or in connection with:

(a) The Arkansas medical assistance program and its contracted insurers, whether providing services on a managed-care or fee-for-service basis;

(b) The state employees' and public school teachers' health insurance programs;

(c) A self-insured group arrangement to the extent not preempted by federal law; and

(d) A managed health care delivery entity of any type or description.

(B) "Health care policy" does not include an accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policy; and

(3) "Persons at high risk for colorectal cancer" means:

(A) Individuals over fifty (50) years of age or who face a high risk for colorectal cancer because of:

(i) The presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy;

(ii) A family history of colorectal cancer in close relatives of parents, brothers, sisters, or children;

(iii) Genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

(iv) A personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or

(v) The presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and

(B) Any additional or expanded definition of "persons at high risk for colorectal cancer" as recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

History. Acts 2005, No. 2236, § 2.

23-79-1202. Coverage — Applicability.

(a) A health care policy subject to this subchapter executed, delivered, issued for delivery, continued, or renewed in this state on or after August 1, 2005, shall include colorectal cancer examinations and laboratory tests within the policy's coverage.

(b) The coverage shall include colorectal cancer examinations and laboratory tests for:

(1) Covered persons who are fifty (50) years of age or older;

(2) Covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and

(3) Covered persons experiencing the following symptoms of colorectal cancer as determined by a physician licensed under the Arkansas Medical Practices Act, §§ 17-95-201 et seq., 17-95-301 et seq., and 17-95-401 et seq.:

(A) Bleeding from the rectum or blood in the stool; or

(B) A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

(c) After August 1, 2005, each employer that offers a health care policy to employees shall offer all eligible employees at the time of hiring or health care policy renewal a policy that includes colorectal cancer examinations and laboratory tests within the coverage of the employee's health care policy.

(d)(1) The colorectal screening shall involve an examination of the entire colon, including:

(A) The following examinations or laboratory tests, or both:

(i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;

(ii) A double-contrast barium enema every five (5) years; or

(iii) A colonoscopy every ten (10) years; and

(B) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

(2) The covered person shall determine the choice of screening strategies in consultation with a health care provider.

(3) Colorectal screening examinations shall be according to the choices and frequency provided by this subsection for all other covered persons.

(e) Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

(1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;

(2) For individuals with one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;

(3) If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and

(4) For patients with large sessile adenomas greater than three centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

History. Acts 2005, No. 2236, § 2.

23-79-1203. Certain activities not prohibited.

(a) This subchapter does not prohibit the issuance of policies that provide benefits greater than those required by § 23-79-1202 or more favorable to the insured than those required by § 23-79-1202.

(b) This subchapter does not prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized by law relating to preferred provider arrangements.

History. Acts 2005, No. 2236, § 2.

23-79-1204. Exclusions and reductions — Benefits subject to annual deductible and coinsurance.

(a) Except as provided in subsection (b) of this section, the coverage offered under § 23-79-1202 may contain any exclusions, reductions, or other limitations approved by the Insurance Commissioner concerning coverages, deductibles, or coinsurance provisions.

(b) The benefits provided in this subchapter shall be subject to the same annual deductible or coinsurance established for all other covered benefits within a health care policy.

History. Acts 2005, No. 2236, § 2.

23-79-1205. Coverage by participating providers — Selection criteria and utilization protocols — Maximum benefits — Exclusions.

(a)(1) This subchapter does not require and shall not be construed to require the coverage of services by providers who are not designated as covered providers or that are not selected as a participating provider by a group health benefit plan or insurer having a participating network of service providers.

(2) This subchapter does not expand the list or designation of participating providers as specified in any health benefit plan.

(b) Insurers or other issuers of any health benefit plan covered by this subchapter may continue to establish and apply selection criteria and utilization protocols for health care providers including:

(1) The designation of types of providers for which coverage is provided; and

(2) Credentialing criteria used in the selection of providers.

(c) A health care policy that provides coverage for the services offered under this subchapter may contain provisions for maximum benefits and coinsurance limitations, deductibles, exclusions, and utilization review protocols to the extent that the provisions are not inconsistent with the requirements of this subchapter.

History. Acts 2005, No. 2236, § 2.

23-79-1206. Additional benefit costs.

The issuer of a health care policy shall conform its policies, contracts, or certificates issued on or after August 1, 2005, and may adjust its premium cost to reflect the additional benefit cost.

History. Acts 2005, No. 2236, § 2.

23-79-1207. Cost-sharing.

(a) To encourage colorectal cancer screenings, patients and health care providers may not be required to meet burdensome criteria or overcome significant obstacles to obtain coverage.

(b) An individual shall not be required to pay an additional deductible or coinsurance for testing that is greater than an annual deductible or coinsurance established for similar benefits.

(c) If the program or contract does not cover a similar benefit, a deductible or coinsurance may not be set at a level that materially diminishes the value of the colorectal cancer benefit required under this subchapter.

(d) Reimbursement to health care providers for colorectal cancer screenings provided under this section shall be equal to or greater than reimbursement to health care providers under Medicare, Title XVII of the Social Security Act, 42 U.S.C. § 1395 et seq., as it existed on January 1, 2005.

History. Acts 2005, No. 2236, § 2.

23-79-1208. Referrals to participating providers.

A health care policy is not required to provide a referral under this subchapter to a nonparticipating health care provider unless the plan or carrier does not have a participating health care provider that is available and accessible to administer the screening, examination, or treatment of colorectal cancer.

History. Acts 2005, No. 2236, § 2.

23-79-1209. Payment of nonparticipating providers.

If a health care policy refers an individual under this subchapter to a nonparticipating health care provider, then services provided under the approved screening exam or resulting treatment, if any, shall be provided at no additional cost to the individual beyond what the individual would otherwise pay to a participating health care provider.

History. Acts 2005, No. 2236, § 2.

Subchapter 13 — Coverage for Prostate Cancer Screening

23-79-1301. Findings.

The General Assembly finds that:

(1) Prostate cancer is the second leading cause of cancer in men;

(2) In Arkansas, more men die from prostate cancer than women die of breast cancer, the tenth-highest death rate in the nation;

(3) Even though the death rate for prostate cancer has decreased in Arkansas, there has been a fifty-five percent (55%) increase in premature death before age sixty-five;

(4) Arkansas's African-American men are fifty-five percent (55%) more likely to develop prostate cancer and one hundred seventy-six percent (176%) more likely to die from prostate cancer than Arkansas's Caucasian men;

(5) The Arkansas Central Cancer Registry data indicates that there has been a steady increase in the number of new cases of prostate cancer and a steady decrease in deaths from prostate cancer in Arkansas since 1999, indicating that there have been improvements in discovering prostate cancer before symptoms appear;

(6) Studies have found that men between fifty (50) years of age and sixty (60) years of age who were diagnosed with prostate cancer were sixty percent (60%) more likely to suffer premature death than those men who were diagnosed at an earlier age;

(7) Identifying the characteristics of high-risk men and fostering early diagnosis and appropriate treatment could:

(A) Prevent premature deaths;

(B) Decrease:

(i) Adverse effects and death from prostate cancer, particularly in the underserved populations;

(ii) Health disparities; and

(iii) Prostate cancer treatment costs through diagnosis at an earlier stage; and

(C) Improve and extend quality of life; and

(8) The cost of treatment per man for:

(A) Early-stage prostate cancer is fifty-eight thousand dollars ($58,000); and

(B) Late-stage prostate cancer is more than ninety-three thousand dollars ($93,000).

History. Acts 2009, No. 75, § 1.

23-79-1302. Definitions.

As used in this subchapter:

(1)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2009.

(C) "Health benefit plan" does not include:

(i) Accidental injury insurance plans;

(ii) Dental insurance plans;

(iii) Vision insurance plans;

(iv) Specified disease insurance plans;

(v) Disability income plans;

(vi) Credit insurance plans;

(vii) Insurance coverage issued as a supplement to liability insurance;

(viii) Medical payments under automobile or homeowners' insurance plans;

(ix) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(x) Insurance under which benefits are payable with or without regard to fault and the benefits that are statutorily required to be contained in any liability policy or equivalent self-insurance; and

(xi) Plans that provide only indemnity for hospital confinement;

(2) "National Comprehensive Cancer Network" means:

(A) A not-for-profit alliance of twenty-one (21) of the world's leading cancer centers dedicated to improving the quality and effectiveness of care provided to patients with cancer; and

(B) With the primary goal of improving the quality, effectiveness, and efficiency of oncology practice so that patients may live better lives; and

(3) "Premature death" means a death that occurs before sixty-five (65) years of age.

History. Acts 2009, No. 75, § 1.

23-79-1303. Coverage for prostate cancer screening required.

(a)(1) A health benefit plan that is offered, issued, or renewed in this state on or after January 1, 2010, and that provides coverage to men forty (40) years of age or older in this state shall provide coverage for screening for the early detection of prostate cancer in men forty (40)

years of age and older according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009.

(2) The coverage for prostate cancer screening required under subdivision (a)(1) of this section:

(A) Is not subject to policy deductibles; and

(B) Shall not exceed the actual cost of the prostate cancer screening up to the maximum allowable cost per screening.

(b) The coverage for prostate cancer screening required under subsection (a) of this section shall be offered as follows:

(1) The prostate cancer screening shall be performed by a qualified medical professional; and

(2) The coverage shall provide at least one (1) screening per year for any man forty (40) years of age or older according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009.

(c) The coverage for prostate cancer screening required under subsection (a) of this section does not diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

(d) If a medical practitioner recommends that an insured, a subscriber, or an enrollee undergo a prostate specific antigen blood test, coverage may not be denied on the ground that the insured, subscriber, or enrollee has already had a digital rectal examination and the examination result was negative.

History. Acts 2009, No. 75, § 1.

Subchapter 14 — Coverage for Hearing Aids

23-79-1401. Definitions.

As used in this subchapter:

(1)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer in this state.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2009.

(C) "Health benefit plan" does not include:

(i) Accidental injury insurance plans;

(ii) Dental insurance plans;

(iii) Vision insurance plans;

(iv) Specified disease insurance plans;

(v) Disability income plans;

(vi) Credit insurance plans;

(vii) Insurance coverage issued as a supplement to liability insurance;

(viii) Medical payments under automobile or homeowners' insurance plans;

(ix) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(x) Insurance under which benefits are payable with or without regard to fault and the benefits that are statutorily required to be contained in any liability policy or equivalent self-insurance; and

(xi) Plans that provide only indemnity for hospital confinement; and

(2) "Hearing aid" means an instrument or device, including repair and replacement parts, that:

(A) Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

(B) Is worn in or on the body; and

(C) Is generally not useful to a person in the absence of a hearing impairment.

History. Acts 2009, No. 1179, § 1.

23-79-1402. Coverage for hearing aids required.

(a) A health benefit plan that is offered, issued, or renewed in this state shall offer coverage for a hearing aid or hearing instrument sold on or after January 1, 2010, by a professional licensed by the state to dispense a hearing aid or hearing instrument.

(b) The coverage offered for hearing aids under this section:

(1) Shall not be for less than one thousand four hundred dollars ($1,400) per ear for each three-year period;

(2) Shall provide coverage of not less than one thousand four hundred dollars ($1,400) per ear beginning on the first day of coverage; and

(3) Is not subject to policy deductibles or copayment requirements.

History. Acts 2009, No. 1179, § 1.

23-79-1403. Rules.

The State Insurance Department shall develop and promulgate rules for the implementation and administration of this subchapter.

History. Acts 2009, No. 1179, § 1.

Subchapter 15 — Coverage for Craniofacial Anomaly Corrective Surgery

23-79-1501. Definitions.

As used in this subchapter:

(1) "Corrective surgery" means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder;

(2) "Craniofacial anomaly" means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue; and

(3)(A) "Health benefit plan" means an individual, blanket, or group plan, policy, or contract for health care services issued or delivered by a health care insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state.

(B) "Health benefit plan" includes:

(i) Indemnity and managed care plans; and

(ii) Governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2013, except governmental self-financed insurance organizations.

(C) "Health benefit plan" does not include:

(i) Disability income plans;

(ii) Credit insurance plans;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) Medical payments under automobile or homeowners' insurance plans;

(v) Health benefit plans provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vi) Plans that provide only indemnity for hospital confinement;

(vii) Accident only plans; or

(viii) Specified disease plans.

History. Acts 2013, No. 1226, § 1.

23-79-1502. Craniofacial anomaly — Coverage for corrective surgery required.

(a)(1) A health benefit plan that is offered, issued, or renewed in this state shall include coverage for corrective surgery and related medical care for a person of any age who is diagnosed as having a craniofacial

anomaly if the surgery and treatment are medically necessary to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team.

(2) A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall:

(A) Evaluate persons with craniofacial anomalies; and

(B) Coordinate a treatment plan for each person.

(3) After one (1) denial or any limitation of coverage that is based on the lack of medical necessity to improve a functional impairment, the case shall be referred for an external review under State Insurance Department Rule 76, the Arkansas External Review Regulation.

(b) Medical care coverage required under this section includes corrective surgery, dental care, vision care, and the use of at least one (1) hearing aid.

History. Acts 2013, No. 1226, § 1.

23-79-1503. Rules.

The State Insurance Department shall develop and promulgate rules for the implementation and administration of this subchapter.

History. Acts 2013, No. 1226, § 1.

CHAPTER 80

INSURANCE POLICIES — SIMPLIFICATION

Subchapter 2 — Life and Accident and Health Insurance Policy Language Simplification Act

23-80-206. Minimum standards.

CASE NOTES

Validity.

There are no cases in which an Arkansas court has declared an insurance policy invalid on the basis of § 23-80-206(a), and § 23-79-118 precludes any relief based on noncompliance with § 23-80-206. Francis v. Protective Life Ins. Co., 98 Ark. App. 1, 249 S.W.3d 828 (2007), appeal dismissed, 371 Ark. 285, 265 S.W.3d 117 (2007).

CHAPTER 81

LIFE INSURANCE POLICIES AND ANNUITIES

SUBCHAPTER.

3. Standard Nonforfeiture Law For Individual Deferred Annuities.
4. Variable Contracts.
6. Viatical Settlements Act. [Repealed.]
7. Structured Settlement Protection Act.

SUBCHAPTER 1 — GENERAL PROVISIONS

23-81-113. Life insurance — Payment of claims provision.

RESEARCH REFERENCES

ALR. What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer. 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy. 116 A.L.R.5th 247.

23-81-116. Life insurance — Holding of proceeds.

CASE NOTES

Pay-On-Death Designations.

Statute-based precedents, including § 23-32-207, § 23-37-502, and this section, do not undermine Coley v. English, 235 Ark. 215, 357 S.W.2d 529 (1962), or similar cases; only the state supreme court can say whether the now-ready availability of pay-on-death designations, insurance products, and other legally effective transfers of future and contingent interests in property has so eroded the line of cases exemplified by Coley that the common law has changed. Miller v. Cothran, 102 Ark. App. 61, 280 S.W.3d 580 (2008), review denied, — Ark. —, — S.W.3d —, 2008 Ark. LEXIS 580 (Sept. 4, 2008).

SUBCHAPTER 3 — STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-81-303. Nonforfeiture requirements.

(a) In the case of contracts issued on or after the operative date of this subchapter as defined in § 23-81-312, no contract of annuity, except as stated in § 23-81-302, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions, which in the opinion of the Insurance Commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract or upon the written request of the contract owner, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in §§ 23-81-305 — 23-81-308 and 23-81-310;

(2)(A) If a contract provides for a lump-sum settlement at maturity or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in §§ 23-81-305, 23-81-306, 23-81-308, and 23-81-310.

(B) The insurer may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability of the deferral to all policyholders;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract, or any prior withdrawals from or partial surrenders of the contract.

(b) Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid prior to the period would be less than twenty dollars ($20.00) monthly, the insurer may at its option terminate the contract by payment in cash of the then-present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by the payment shall be relieved of any further obligation under the contract.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1; Acts 2005, No. 506, § 41.

23-81-304. Minimum values.

(a)(1) Prior to July 15, 2006, a company may elect to comply with the provisions of:

(A) Subsections (b) and (c) of this section; or

(B) Subsections (d)-(f) of this section.

(2) On and after July 15, 2006, all companies shall comply with the provisions of subsections (d)-(f) of this section.

(b) The minimum values as specified in §§ 23-81-305 — 23-81-308 and 23-81-310 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this subchapter.

(c)(1)(A) With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of one and one-half percent (1.5%) per annum of percentages of the net considerations paid prior to the time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of one and one-half percent (1.5%) per annum; and

(ii) The amount of any indebtedness to the insurer on the contract, including interest due and accrued and increased by any existing additional amounts credited by the insurer to the contract.

(B)(i) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero (0) and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of thirty dollars ($30.00) and less a collection charge of one dollar and twenty-five cents ($1.25) per consideration credited to the contract during that contract year.

(ii) The percentages of net considerations shall be sixty-five percent (65%) of the net consideration for the first contract year and eighty-seven and one-half percent (87.5%) of the net considerations for the second and later contract years.

(iii) Notwithstanding the provisions of subdivision (c)(1)(B)(ii) of this section, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year that exceeds by not more than two (2) multiplied by the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

(2) With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations that are paid annually, with two (2) exceptions:

(A) The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent (65%) of the net consideration for the first contract year plus twenty-two and one-half percent (22.5%) of the excess of the net considerations for the first contract year over the lesser of the net considerations for the second and third contract years; and

(B) The annual contract charge shall be the lesser of thirty dollars ($30.00) or ten percent (10%) of the gross annual consideration.

(3) With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations, except that the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent (90%) and the net consideration shall be the gross consideration less a contract charge of seventy-five dollars ($75.00).

(d) On and after July 15, 2006, the minimum values as specified in §§ 23-81-305 — 23-81-308 and 23-81-310 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in subsections (e) and (f) of this section.

(e)(1)(A) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest as indicated in subdivisions (e)(2) and (3) of this section of the net considerations paid prior to the time, decreased by the sum of:

(i) Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest as indicated in subdivisions (e)(2) and (3) of this section;

(ii) An annual contract charge of fifty dollars ($50.00) accumulated at a rate of interest as indicated in subdivisions (e)(2) and (3) of this section;

(iii) Any premium tax paid by the company for the contract accumulated at a rate of interest as indicated in subdivisions (e)(2) and (3) of this section; and

(iv) The amount of an indebtedness to the insurer on the contract, including interest due and accrued.

(B) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of gross considerations credited to the contract during that contract year.

(2) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest equal to the lesser of:

(A) Three percent (3%) per annum; or

(B) The following rate, which shall be specified in the contract if the interest rate is reset:

(i) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve System as of a date or average over a period rounded to the nearest one-twentieth of one percent (.05%) that is specified in the contract no longer than fifteen (15) months prior to the contract

issue date or redetermination date under subdivision (e)(3) of this section, reduced by one hundred twenty-five (125) basis points; and

(ii) The resulting interest rate shall not be less than one percent (1%).

(3)(A) The interest rate under subdivision (e)(2) of this section shall apply for an initial period and may be redetermined for additional periods.

(B)(i) The redetermination date, basis, and period, if any, shall be stated in the contract.

(ii) The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(f)(1) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subdivisions (e)(2) and (3) of this section by up to an additional one hundred (100) basis points to reflect the value of the equity index benefit.

(2) The present value of the additional reduction at the contract issue date and at each redetermination date shall not exceed the market value of the benefit.

(3)(A) The Insurance Commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.

(B) If no demonstration is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(g) The commissioner may adopt rules to implement the provisions of subsection (d) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the commissioner determines adjustments are justified.

History. Acts 1981, No. 492, § 1; A.S.A. 1947, § 66-3327.1; Acts 2003, No. 669, § 122. § 1; 2005, No. 506, § 42; 2005, No. 1962,

23-81-313. Rules and regulations.

The Insurance Commissioner may adopt rules and regulations to implement the provisions of this subchapter.

History. Acts 2005, No. 506, § 43.

Subchapter 4 — Variable Contracts

SECTION.

23-81-401. Exceptions from Arkansas Insurance Code.

(a)(1) All pertinent provisions of the Arkansas Insurance Code shall apply to separate accounts and contracts relating to those accounts, except:

(A) Sections 23-81-122, 23-81-127, and 23-81-128 in the case of a variable annuity contract;

(B) Sections 23-81-104, 23-81-109 — 23-81-111, and § 23-81-201 et seq. in the case of a variable life insurance policy;

(C) Section 23-83-109 in the case of group variable life insurance; and

(D) As otherwise provided in this subchapter.

(2) Any group or individual variable life insurance contract or annuity contract delivered or issued for delivery in this state shall contain grace, reinstatement, and nonforfeiture provisions appropriate to the contract.

(b) The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guaranteed.

History. Acts 1975, No. 728, § 5; A.S.A 1947, § 66-3341; Acts 2007, No. 827, § 187.

Subchapter 6 — Viatical Settlements Act

SECTION.
23-81-601 — 23-81-615. [Repealed.]

23-81-601 — 23-81-615. [Repealed.]

Publisher's Notes. This subchapter was repealed by Acts 2009, No. 796, § 2. The subchapter was derived from the following sources:

23-81-601. Acts 2003, No. 1782, § 1.
23-81-602. Acts 2003, No. 1782, § 1.
23-81-603. Acts 2003, No. 1782, § 1.
23-81-604. Acts 2003, No. 1782, § 1.
23-81-605. Acts 2003, No. 1782, § 1.
23-81-606. Acts 2003, No. 1782, § 1.
23-81-607. Acts 2003, No. 1782, § 1.
23-81-608. Acts 2003, No. 1782, § 1.
23-81-609. Acts 2003, No. 1782, § 1.
23-81-610. Acts 2003, No. 1782, § 1.
23-81-611. Acts 2003, No. 1782, § 1.
23-81-612. Acts 2003, No. 1782, § 1.
23-81-613. Acts 2003, No. 1782, § 1.
23-81-614. Acts 2003, No. 1782, § 1.
23-81-615. Acts 2003, No. 1782, § 1.

Subchapter 7 — Structured Settlement Protection Act

SECTION.
23-81-701. Title.
23-81-702. Definitions.
23-81-703. Required disclosures to payee.
23-81-704. Approval of transfers of structured settlement payment rights.

23-81-701. Title.

This subchapter shall be known and may be cited as the "Structured Settlement Protection Act".

History. Acts 2005, No. 2215, § 1.

23-81-702. Definitions.

As used in this subchapter:

(1) "Annuity issuer" means an insurer that has issued a contract to fund periodic payments under a structured settlement;

(2) "Dependents" includes a payee's spouse and minor children and all other persons for whom the payee is legally obligated to provide support, including alimony;

(3) "Discounted present value" means the present value of future payments determined by discounting such payments to the present using the most recently published applicable federal rate for determining the present value of an annuity, as issued by the Internal Revenue Service;

(4) "Gross advance amount" means the sum payable to the payee or for the payee's account as consideration for a transfer of structured settlement payment rights before any reductions for transfer expenses or other deductions are made from the consideration;

(5) "Independent professional advice" means advice of an attorney, certified public accountant, actuary, or other licensed professional adviser;

(6) "Interested parties" means, with respect to any structured settlement:

(A) The payee;

(B) Any beneficiary irrevocably designated under the annuity contract to receive payments following the payee's death;

(C) The annuity issuer;

(D) The structured settlement obligor; and

(E) Any other party that has continuing rights or obligations under the structured settlement;

(7) "Net advance amount" means the gross advance amount less the aggregate amount of the actual and estimated transfer expenses required to be disclosed under § 23-81-703(5);

(8) "Payee" means an individual who is receiving tax-free payments under a structured settlement and proposes to make a transfer of payment rights under the structured settlement;

(9) "Periodic payments" includes both recurring payments and scheduled future lump-sum payments;

(10) "Qualified assignment agreement" means an agreement providing for a qualified assignment within the meaning of section 130 of the Internal Revenue Code of 1986, as in existence on January 1, 2005;

(11) "Responsible administrative authority" means, with respect to a structured settlement, any government authority vested by law with exclusive jurisdiction over the settled claim resolved by the structured settlement;

(12) "Settled claim" means the original tort claim or workers' compensation claim resolved by a structured settlement;

(13) "Structured settlement" means an arrangement for periodic payment of damages for personal injuries or sickness established by settlement or judgment in resolution of a tort claim or for periodic payments in settlement of a workers' compensation claim;

(14) "Structured settlement agreement" means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement;

(15) "Structured settlement obligor" means, with respect to any structured settlement, the party that has the continuing obligation to make periodic payments to the payee under a structured settlement agreement or a qualified assignment agreement;

(16) "Structured settlement payment rights" means rights to receive periodic payments under a structured settlement, whether from the structured settlement obligor or the annuity issuer, when:

(A) The payee is domiciled in or the domicile or principal place of business of the structured settlement obligor or the annuity issuer is located in this state;

(B) The structured settlement agreement was approved by a court or responsible administrative authority in this state; or

(C) The structured settlement agreement is expressly governed by the laws of this state;

(17) "Terms of the structured settlement" includes, with respect to any structured settlement:

(A) The terms of the structured settlement agreement;

(B) The annuity contract;

(C) Any qualified assignment agreement; and

(D) Any order or other approval of any court or responsible administrative authority or other government authority that authorized or approved the structured settlement;

(18)(A) "Transfer" means any sale, assignment, pledge, hypothecation, or other alienation or encumbrance of structured settlement payment rights made by a payee for consideration.

(B) However, "transfer" does not include the creation or perfection of a security interest in structured settlement payment rights under a blanket security agreement entered into with an insured depository institution, in the absence of any action to redirect the structured settlement payments to the insured depository institution or an agent or successor in interest, or otherwise to enforce the blanket security interest against the structured settlement payment rights;

(19) "Transfer agreement" means the agreement providing for a transfer of structured settlement payment rights;

(20)(A) "Transfer expenses" means all expenses of a transfer that are required under the transfer agreement to be paid by the payee or deducted from the gross advance amount, including, without limitation:

(i) Court filing fees;

(ii) Attorney's fees;

(iii) Escrow fees;

(iv) Lien recordation fees;

(v) Judgment and lien search fees;

(vi) Finders' fees;

(vii) Commissions; and

(viii) Other payments to a broker or other intermediary.

(B) "Transfer expenses" does not include preexisting obligations of the payee payable for the payee's account from the proceeds of a transfer; and

(21) "Transferee" means a party acquiring or proposing to acquire structured settlement payment rights through a transfer.

History. Acts 2005, No. 2215, § 1.
U.S. Code. Section 130 of the Internal Revenue Code of 1986, referred to in (10), is codified as 26 U.S.C. § 130.

23-81-703. Required disclosures to payee.

Not less than three (3) days prior to the date on which a payee signs a transfer agreement, the transferee shall provide to the payee a separate disclosure statement in bold type no smaller than fourteen (14) points, setting forth:

(1) The amounts and due dates of the structured settlement payments to be transferred;

(2) The aggregate amount of the payments;

(3) The discounted present value of the payments to be transferred, which shall be identified as the "calculation of current value of the transferred structured settlement payments under federal standards for valuing annuities", and the amount of the applicable federal rate used in calculating the discounted present value;

(4) The gross advance amount;

(5) An itemized listing of all applicable transfer expenses, other than attorney's fees and related disbursements payable in connection with the transferee's application for approval of the transfer, and the transferee's best estimate of the amount of any such fees and disbursements;

(6) The net advance amount;

(7) The amount of any penalties or liquidated damages payable by the payee in the event of any breach of the transfer agreement by the payee; and

(8) A statement that the payee has the right to cancel the transfer agreement, without penalty or further obligation, not later than the third business day after the date the agreement is signed by the payee.

History. Acts 2005, No. 2215, § 1.

23-81-704. Approval of transfers of structured settlement payment rights.

No direct or indirect transfer of structured settlement payment rights shall be effective and no structured settlement obligor or annuity issuer shall be required to make any payment directly or indirectly to any transferee of structured settlement payment rights unless the transfer has been approved in advance in a final court order or order of a responsible administrative authority based on express findings by the court or responsible administrative authority that:

(1) The transfer is in the best interest of the payee, taking into account the welfare and support of the payee's dependents;

(2) The payee has been advised in writing by the transferee to seek independent professional advice regarding the transfer and has either received the advice or knowingly waived the advice in writing; and

(3) The transfer does not contravene any applicable statute or the order of any court or other government authority.

History. Acts 2005, No. 2215, § 1.

23-81-705. Effects of transfer of structured settlement payment rights.

Following a transfer of structured settlement payment rights under this subchapter:

(1) The structured settlement obligor and the annuity issuer shall be discharged and released from all liability for the transferred payments as to all parties except the transferee;

(2) The transferee shall be liable to the structured settlement obligor and the annuity issuer:

(A) If the transfer contravenes the terms of the structured settlement, for any taxes incurred by such parties as a consequence of the transfer; and

(B) For any other liabilities or costs, including reasonable costs and attorney's fees, arising from compliance by the parties with the order of the court or responsible administrative authority or arising as a consequence of the transferee's failure to comply with this subchapter;

(3) Neither the annuity issuer nor the structured settlement obligor may be required to divide any periodic payment between the payee and any transferee or assignee or between two (2) or more transferees or assignees; and

(4) Any further transfer of structured settlement payment rights by the payee may be made only after compliance with all of the requirements of this subchapter.

History. Acts 2005, No. 2215, § 1.

23-81-706. Procedure for approval of transfers.

(a) An application under this subchapter for approval of a transfer of structured settlement payment rights shall be made by the transferee and may be brought:

(1) In the county in which:

(A) The payee resides; or

(B) The structured settlement obligor or the annuity issuer maintains its principal place of business; or

(2) In any court or before any responsible administrative authority which approved the structured settlement agreement.

(b) Not less than twenty (20) days prior to the scheduled hearing on any application for approval of a transfer of structured settlement payment rights under § 23-81-704, the transferee shall file with the court or responsible administrative authority and serve on all interested parties a notice of the proposed transfer and the application for its authorization, including with the notice:

(1) A copy of the transferee's application;

(2) A copy of the transfer agreement;

(3) A copy of the disclosure statement required under § 23-81-703;

(4) A listing of each of the payee's dependents and each dependent's age;

(5) Notification that any interested party is entitled to support, oppose, or otherwise respond to the transferee's application, either in person or by counsel, by submitting written comments to the court or responsible administrative authority or by participating in the hearing; and

(6)(A) Notification of:

(i) The time and place of the hearing; and

(ii) The manner in which and the time by which written responses to the application must be filed in order to be considered by the court or responsible administrative authority.

(B) The time by which written responses to the application must be filed shall be not less than twenty (20) days after service of the transferee's notice.

History. Acts 2005, No. 2215, § 1.

23-81-707. General provisions — Construction.

(a) The provisions of this subchapter may not be waived by any payee.

(b)(1) Any transfer agreement entered into on or after August 12, 2005, by a payee who resides in this state shall provide that disputes

under the transfer agreement, including any claim that the payee has breached the agreement, shall be determined in and under the laws of the State of Arkansas.

(2) No transfer agreement shall authorize the transferee or any other party to confess judgment or consent to entry of judgment against the payee.

(c) No transfer of structured settlement payment rights shall extend to any payments that are life-contingent unless prior to the date on which the payee signs the transfer agreement, the transferee has established and has agreed to maintain procedures reasonably satisfactory to the annuity issuer and the structured settlement obligor for:

(1) Periodically confirming the payee's survival; and

(2) Giving the annuity issuer and the structured settlement obligor prompt written notice in the event of the payee's death.

(d) No payee who proposes to make a transfer of structured settlement payment rights shall incur any penalty, forfeit any application fee or other payment, or otherwise incur any liability to the proposed transferee or any assignee based on any failure of the transfer to satisfy the conditions of this subchapter.

(e) Nothing contained in this subchapter shall be construed to authorize any transfer of structured settlement payment rights in contravention of any law or to imply that any transfer under a transfer agreement entered into prior to August 12, 2005, is valid or invalid.

(f) Compliance with the requirements set forth in § 23-81-703 and fulfillment of the conditions set forth in § 23-81-704 shall be solely the responsibility of the transferee in any transfer of structured settlement payment rights, and neither the structured settlement obligor nor the annuity issuer shall bear any responsibility for or any liability arising from noncompliance with the requirements or failure to fulfill the conditions.

History. Acts 2005, No. 2215, § 1.

Subchapter 8 — Life Settlements Act

23-81-801. Short title.

This subchapter shall be known and may be cited as the "Life Settlements Act".

History. Acts 2009, No. 796, § 1.

23-81-802. Definitions.

As used in this subchapter:

(1) "Advertisement" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmissions on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, to create an interest in or to induce a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract;

(2)(A) "Broker" means a person who on behalf of an owner and for a fee, commission, or other valuable consideration offers or attempts to negotiate life settlement contracts between an owner and providers.

(B) A broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions and in the best interest of the owner, notwithstanding the manner in which the broker is compensated.

(C) "Broker" does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in his or her professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person except the owner;

(3) "Business of life settlements" means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking life settlement contracts;

(4) "Chronically ill" means:

(A) Being unable to perform at least two (2) activities of daily living such as eating, toileting, transferring, bathing, dressing, or continence;

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(C) Having a level of disability similar to that described in subdivision (4)(A) of this section as determined by regulations of the United States Secretary of Health and Human Services if adopted by rule of the Insurance Commissioner;

(5)(A) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but:

(i) Whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one (1) or more policies; and

(ii) Has an agreement in writing with one (1) or more providers to finance the acquisition of life settlement contracts.

(B) "Financing entity" does not include a nonaccredited investor or purchaser;

(6) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity, including without limitation any secured or unsecured financing, any securitization transaction, or any securities offering that either is registered or exempt from registration under federal and state securities law;

(7) "Fraudulent life settlement act" includes:

(A) Acts or omissions committed by a person who knowingly and with intent to defraud for the purpose of depriving another of property or for pecuniary gain commits or permits its employees or its agents to engage in acts, including without limitation:

(i) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, broker, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one (1) or more of the following:

(a) An application for the issuance of a life settlement contract or insurance policy;

(b) The underwriting of a life settlement contract or insurance policy;

(c) A claim for payment or benefit pursuant to a life settlement contract or insurance policy;

(d) Premiums paid on an insurance policy;

(e) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or insurance policy;

(f) The reinstatement or conversion of an insurance policy;

(g) The solicitation, offer to enter into, or effectuation of a life settlement contract or insurance policy;

(h) The issuance of written evidence of life settlement contracts or insurance;

(i) Any application for or the existence of or any payments related to a loan secured directly or indirectly by any interest in a life insurance policy; or

(j) Entering into any practice or plan that involves stranger-originated life insurance;

(ii) Failing to disclose to the insurer when the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy;

(iii) Employing any device, scheme, or artifice to defraud in the business of life settlements; or

(iv) In the solicitation, application, or issuance of a life insurance policy, employing any device, scheme, or artifice in violation of state insurable interest laws; and

(B) In the furtherance of a fraud or to prevent the detection of a fraud, any person commits or permits its employees or its agents to:

(i) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(ii) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(iv) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the commissioner;

(v) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, insurer, insured, owner, insurance, policy owner, or any other person engaged in the business of life settlements or insurance;

(vi) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing for the purpose of misleading another information concerning any fact material to the policy, when the owner or the owner's agent intended to defraud the policy's issuer;

(vii) Attempt to commit, assist, aid, or abet in the commission of or conspiracy to commit the acts or omissions specified in this subdivision (7); or

(viii) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this subchapter for the purpose of evading or avoiding the provisions of this subchapter;

(8) "Insured" means the person covered under the policy being considered for sale in a life settlement contract;

(9) "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live considering medical records and appropriate experiential data;

(10) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to § 23-64-507(a)(1);

(11)(A) "Life settlement contract" means a written agreement entered into between a provider and an owner, establishing the terms

under which compensation or anything of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation, provided, however, that the minimum value for a life settlement contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract.

(B) "Life settlement contract" also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one (1) or more life insurance contracts, which life insurance contract insures the life of a person residing in this state.

(C) "Life settlement contract" also includes a premium finance loan made for a policy on or before the date of issuance of the policy when:

(i) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(ii) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(iii) The owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(D) "Life settlement contract" does not include:

(i) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(ii) A premium finance loan, as defined herein, or any loan made by a bank or other licensed financial institution, provided that neither default on the loan nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this subchapter;

(iii) A collateral assignment of a life insurance policy by an owner;

(iv) An agreement in which all the parties:

(a) Are closely related to the insured by blood or law; or

(b) Have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured or are trusts established primarily for the benefit of such parties;

(v) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer or trust established by the employer of life insurance on the life of the employee;

(vi) A bona fide business succession planning arrangement:

(a) Between one (1) or more shareholders in a corporation or between a corporation and one (1) or more of its shareholders or one (1) or more trusts established by its shareholders;

(b) Between one (1) or more partners in a partnership or between a partnership and one (1) or more of its partners or one (1) or more trusts established by its partners; or

(c) Between one (1) or more members in a limited liability company or between a limited liability company and one (1) or more of its members or one (1) or more trusts established by its members; or

(vii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business;

(12) "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens;

(13)(A) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract.

(B) "Owner" is not limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except when specifically addressed.

(C) "Owner" does not include:

(i) Any provider or other licensee under this subchapter;

(ii) A qualified institutional buyer as defined in Rule 144A of the Federal Securities Act of 1933, as amended;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust;

(14) "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured;

(15) "Person" means any natural person or legal entity, including without limitation a partnership, limited liability company, association, trust, or corporation;

(16) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state;

(17) "Premium finance loan" means a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy;

(18)(A) "Provider" means a person other than an owner who enters into or effectuates a life settlement contract with an owner.

(B) "Provider" does not include:

(i) Any bank, savings bank, savings and loan association, or credit union;

(ii) A licensed lending institution or creditor or secured party pursuant to a premium finance loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

(iii) The insurer of a life insurance policy or rider to the extent it provides accelerated death benefits or cash surrender value under the insurance code or rules of the commissioner;

(iv) Any natural person who enters into or effectuates no more than one (1) agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy for compensation or anything of value less than the expected death benefit payable under the policy;

(v) A purchaser;

(vi) Any authorized or eligible insurer that provides stop loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

(vii) A financing entity;

(viii) A special purpose entity;

(ix) A related provider trust;

(x) A broker; or

(xi) An accredited investor or qualified institutional buyer as defined in, respectively, Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, who purchases a life settlement policy from a provider;

(19) "Purchased policy" means a policy or group certificate that has been acquired by a provider pursuant to a life settlement contract;

(20) "Purchaser" means a person who pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a life settlement contract;

(21)(A) "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction.

(B) In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the State Insurance Department as if those records and files were maintained directly by the licensed provider;

(22) "Settled policy" means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract;

(23) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets:

(A) For a financing entity or provider; or

(B) In connection with a transaction in which:

(i) The securities in the special purpose entity are acquired by the owner or by a qualified institutional buyer, as defined in Rule 144A as promulgated under the Federal Securities Act of 1933, as amended; or

(ii) The securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets;

(24)(A) "Stranger-originated life insurance" is a practice or plan to initiate a life insurance policy for the benefit of a third-party investor who at the time of policy origination has no insurable interest in the insured.

(B) Stranger-originated life insurance practices include without limitation cases in which life insurance is purchased with resources or guarantees from or through a person or entity that at the time of policy inception could not lawfully initiate the policy himself, herself, or itself, and in which at the time of inception there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy, the policy benefits, or the policy and the policy benefits to a third party.

(C) Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life.

(D) Stranger-originated life insurance arrangements do not include those practices set forth in subdivision (11)(D) of this section; and

(25) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less.

History. Acts 2009, No. 796, § 1.

23-81-803. Licensing requirements.

(a) A person, wherever located, shall not act as a provider or broker with an owner or multiple owners who is a resident of this state without first having obtained a license from the Insurance Commissioner.

(b)(1) Application for a provider or broker license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and the application shall be accompanied by a fee in an amount established by the commissioner.

(2) However, the license and fees to continue the license for a provider license shall be reasonable, and the license and fees to continue the license for a broker license shall not exceed those established for an insurance producer, as such fees are otherwise provided for by statute or rule of the commissioner.

(c) A life insurance producer who has been licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one (1) year and is licensed as a nonresident

producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a broker.

(d)(1) Not later than thirty (30) days from the first day of operating as a broker, the life insurance producer shall notify the commissioner that he or she is acting as a broker on a form prescribed by the commissioner and shall pay any applicable fee to be determined by the commissioner.

(2) Notification shall include an acknowledgement by the life insurance producer that he or she will operate as a broker in accordance with this subchapter.

(e) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a broker or provider or purchaser arising out of or in connection with the life settlement transaction unless the insurer receives compensation for the placement of a life settlement contract from the provider or purchaser or broker in connection with the life settlement contract.

(f) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a broker.

(g)(1) Licenses issued under this subchapter may be continued by paying the fees and satisfying the education and other requirements established by rule of the commissioner.

(2) Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license.

(h)(1) The applicant shall provide such information as the commissioner may require on forms prepared by the commissioner.

(2) The commissioner may require the applicant to fully disclose the identity of its stockholders other than stockholders owning less than ten percent (10%) of the shares of an applicant whose shares are publicly traded, partners, officers, and employees, and the commissioner, in the exercise of the commissioner's sole discretion, may refuse to issue such a license in the name of any person if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of §§ 23-81-801 — 23-81-814.

(i) A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as licensees under the license, if those persons are named in the application and any supplements to the application.

(j) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and may issue a license if the commissioner finds that the applicant:

(1) If a provider, has provided a detailed plan of operation;

(2) Is competent and trustworthy and intends to transact its business in good faith;

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied;

(4) If the applicant is a legal entity, is formed or organized pursuant to the laws of this state, is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile; and

(5) Has provided to the commissioner an antifraud plan that meets the requirements of § 23-81-814 and includes:

(A) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting fraudulent insurance acts to the commissioner;

(C) A description of the plan for antifraud education and training of its underwriters and other personnel; and

(D) A written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(k) The commissioner shall not issue any license to any nonresident applicant unless a written designation of an agent for service of process is filed under § 4-20-112 and maintained with the commissioner or unless the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the commissioner.

(l) Each licensee shall file with the commissioner on or before March 1 of each year an annual statement containing such information as the commissioner by rule may prescribe.

(m) A provider shall not use any person to perform the functions of a broker as defined in this subchapter unless the person holds a current, valid license as a broker, as provided in this section.

(n) A broker shall not use any person to perform the functions of a provider as defined in this subchapter unless the person holds a current, valid license as a provider, as provided in this section.

(o) A provider or broker shall provide to the commissioner new or revised information about officers, ten percent (10%) or more stockholders, partners, directors, members, or designated employees within thirty (30) days of the change.

(p)(1)(A) An individual licensed as a broker shall complete on a biennial basis a minimum of fifteen (15) hours of training related to life settlements and life settlement transactions, as required by the commissioner.

(B) However, a life insurance producer who is operating as a broker pursuant to this section shall not be subject to the requirements of this subsection.

(2) Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the commissioner.

History. Acts 2009, No. 796, § 1.

23-81-804. License suspension, revocation, or refusal to renew.

(a) The Insurance Commissioner may suspend, revoke, or refuse to renew the license of any licensee if the commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

(3) The provider demonstrates a pattern of unreasonably withholding payments to policy owners;

(4) The licensee no longer meets the requirements for initial licensure;

(5) The licensee or any officer, partner, member, or director has been convicted of a felony or of any misdemeanor of which criminal fraud is an element or the licensee has pleaded guilty or nolo contendere with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless of whether a judgment of conviction has been entered by the court;

(6) The provider has entered into any life settlement contract using a form that has not been approved pursuant to this subchapter;

(7) The provider has failed to honor contractual obligations set out in a life settlement contract;

(8) The provider has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, a purchaser, or an accredited investor or qualified institutional buyer as defined in, respectively, Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, a financing entity, a special purpose entity, or a related provider trust; or

(9) The licensee or any officer, partner, member, or key management personnel has violated provisions of this subchapter.

(b)(1) The commissioner may deny a license application or suspend, revoke, or refuse to renew a license of a licensee for the licensee's failure to comply with this subchapter.

(2) A proceeding under this subsection is subject to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

History. Acts 2009, No. 796, § 1; 2013, No. 355, § 13.

Amendments. The 2013 amendment rewrote (b).

23-81-805. Contract requirements.

(a) A person shall not use any form of life settlement contract in this state unless it has been filed with and approved, if required, by the Insurance Commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies, and contracts.

(b) An insurer shall not as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract require that the owner, insured, provider, or broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the commissioner for use in connection with life settlement contracts in this state.

(c)(1) A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the commissioner.

(2) The commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained in the life settlement contract form or disclosure statement form fail to meet the requirements of §§ 23-81-808 — 23-81-811 and 23-81-815(b) or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner.

(3) At the commissioner's discretion, the commissioner may require the submission of advertising material.

History. Acts 2009, No. 796, § 1.

23-81-806. Reporting requirements and privacy.

(a)(1)(A) For any policy settled within five (5) years of policy issuance, each provider shall file with the Insurance Commissioner on or before March 1 of each year an annual statement containing such information as the commissioner may prescribe by rule.

(B) In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year.

(C) The annual statement shall also include the names of the insurance companies whose policies have been settled and the brokers that have settled the policies.

(2) The information shall be limited to only those transactions in which the owner is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

(3) Every provider that willfully fails to file an annual statement as required in this section or willfully fails to reply within thirty (30) days to a written inquiry by the commissioner in connection therewith, in addition to other penalties provided by this chapter, shall be subject

upon due notice and opportunity to be heard to a penalty of up to two hundred fifty dollars ($250) per day of delay, not to exceed twenty-five thousand dollars ($25,000) in the aggregate for each such failure.

(b) Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

(2) Is necessary to effectuate the sale of life settlement contracts, or interests in life settlement contracts, as investments, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or pursuant to the requirements of § 23-81-813;

(4) Is a term or condition to the transfer of a policy by one (1) provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of this subsection;

(5)(A) Is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status.

(B) For the purposes of subdivision (b)(5)(A) of this section, "authorized representative" does not include any person who has or may have any financial interest in the settlement contract other than a provider, licensed broker, financing entity, related provider trust, or special purpose entity.

(C) A provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this subchapter; or

(6) Is required to purchase stop loss coverage.

(c) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the Gramm-Leach-Bliley Act, Pub. L. No. 106-102 (1999), and all other state and federal laws relating to confidentiality of nonpublic personal information.

History. Acts 2009, No. 796, § 1.

23-81-807. Examination.

(a)(1) When the Insurance Commissioner deems it reasonably necessary to protect the interests of the public, the commissioner may examine the business and affairs of any licensee or applicant for a license.

(2) The commissioner may order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public.

(3) The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(b) In lieu of an examination under this subchapter of any foreign or alien licensee licensed in this state, at the commissioner's discretion, the commissioner may accept an examination report on the licensee as prepared by the commissioner for the licensee's state of domicile or port-of-entry state.

(c) Names of and individual identification data for all owners and insureds shall be considered private and confidential information and shall not be disclosed by the commissioner unless required by law.

(d) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three (3) years after the death of the insured and shall be available to the commissioner for inspection during reasonable business hours.

(e) Conduct of Examinations.

(1)(A) Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one (1) or more examiners to perform the examination and instructing them as to the scope of the examination.

(B) In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and shall use those guidelines and procedures set forth in an examiner's handbook adopted by a national organization prescribed by rule of the commissioner.

(2)(A) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined.

(B) The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so.

(C) The refusal of a licensee or the licensee's officers, directors, employees, or agents to submit to examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the commissioner's jurisdiction.

(D) Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to § 23-61-301 et seq. and the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(3)(A) The commissioner may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination.

(B) Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction for an order to compel the witness to obey the subpoena, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

(4) When making an examination under this subchapter, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5)(A) This subchapter does not limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state.

(B) Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) Any information gathered during an examination as provided in this subchapter shall be deemed confidential pursuant to § 23-61-207.

(f) Examination Reports.

(1) Examination reports shall be composed of only facts appearing upon the books, from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2)(A) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath.

(B) Upon receipt of the verified report, the commissioner shall transmit the report to the licensee that has been examined, together with a notice that shall afford the licensee that has been examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute.

(3) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions provided by law.

(g) Confidentiality of Examination Information.

(1) Names and individual identification data for all owners, purchasers, and insureds shall be considered private and confidential information and shall not be disclosed by the commissioner unless the disclosure is to another regulator or is required by law.

(2)(A) Except as otherwise provided in this subchapter, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this subchapter or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be open to inspection to the public or subject to disclosure under the Freedom of Information Act of 1967, § 25-19-101 et seq., shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(B) The commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(C) The licensee being examined may have access to all documents used to make the report.

(h) Conflict of Interest.

(1) An examiner shall not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this subchapter. This subsection does not automatically preclude an examiner from being:

(A) An owner;

(B) An insured in a life settlement contract or insurance policy; or

(C) A beneficiary in an insurance policy that is proposed for a life settlement contract.

(2) Notwithstanding the requirements of this subsection, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions even though these persons may from time to time be similarly employed or retained by persons subject to examination under this subchapter.

(i) Immunity from Liability.

(1) A cause of action shall not arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives, or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out this subchapter.

(2)(A) A cause of action shall not arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under this subchapter if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(B) This subsection does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subdivision (i)(1) of this section.

(3)(A) A person identified in subdivision (i)(1) or subdivision (i)(2) of this section is entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this subchapter and the party bringing the action was not substantially justified in doing so.

(B) For purposes of this subsection, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(j) Investigative Authority of the Commissioner. The commissioner may investigate suspected fraudulent life settlement acts and persons engaged in the business of life settlements.

(k) Cost of Examinations. Costs of examinations under this subchapter shall be paid to the State Insurance Department to the same extent as examination expenses are imposed on persons pursuant to § 23-61-206.

History. Acts 2009, No. 796, § 1.

23-81-808. Advertising.

(a)(1) A broker or provider licensed pursuant to this subchapter may conduct or participate in advertisements within this state.

(2) Advertisements shall comply with all advertising and marketing laws or rules promulgated by the Insurance Commissioner that are applicable to life insurers or to brokers and providers licensed pursuant to this subchapter.

(b) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(c) A person or trust shall not:

(1) Directly or indirectly market, advertise, solicit, or otherwise promote the purchase of a policy for the sole purpose of or with an emphasis on settling the policy; or

(2) Use the words "free", "no cost", or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy.

History. Acts 2009, No. 796, § 1.

23-81-809. Disclosures to owners.

(a) The provider or broker shall provide in writing in a separate document that is signed by the owner and provider or broker the following information to the owner no later than the date of the application for a life settlement contract:

(1) The fact that possible alternatives to life settlement contracts exist, including without limitation accelerated benefits offered by the issuer of the life insurance policy;

(2) The fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax advisor;

(3) The fact that the proceeds from a life settlement contract could be subject to the claims of creditors;

(4) The fact that receipt of proceeds from a life settlement contract may adversely affect a recipient's eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5)(A) The fact that the owner has a right to terminate a life settlement contract within fifteen (15) days of the date it is executed by all parties and the owner has received the disclosures required by this section.

(B) Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period.

(C) If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider;

(6) The fact that proceeds will be sent to the owner within three (3) business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(7) The fact that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the owner, and that assistance should be sought from a professional financial advisor;

(8) The amount and method of calculating the compensation paid or to be paid to the broker or any other person acting for the owner in connection with the transaction, wherein the term "compensation" includes anything of value paid or given;

(9) The date by which the funds will be available to the owner and the transmitter of the funds;

(10) The fact that the Insurance Commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process;

(11) The following language:

"All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked

to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.";

(12) The fact that the commissioner shall require providers and brokers to print separate signed fraud warnings on their applications and on their life settlement contracts as follows:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.";

(13)(A) The fact that the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address.

(B) This contact is limited to one (1) time every three (3) months if the insured has a life expectancy of more than one (1) year and no more than one (1) time per month if the insured has a life expectancy of one (1) year or less;

(14) The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;

(15) That a broker represents exclusively the owner and not the insurer or the provider or any other person and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;

(16) The name, address, and telephone number of the provider;

(17) The name, business address, and telephone number of the independent third-party escrow agent and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

(18) The fact that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one (1) life.

(b) The written disclosures shall be conspicuously displayed in any life settlement contract furnished to the owner by a provider, including any affiliations or contractual arrangements between the provider and the broker.

(c) A broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(1) The name, business address, and telephone number of the broker;

(2) A full, complete, and accurate description of all the offers, counteroffers, acceptances, and rejections relating to the proposed life settlement contract;

(3) A written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contracts;

(4) The name of each broker who receives compensation and the amount of compensation received by that broker. The compensation includes anything of value paid or given to the broker in connection with the life settlement contract;

(5)(A) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner.

(B) For the purpose of subdivision (c)(5)(A) of this section, "gross offer or bid" means the total amount or value offered by the provider for the purchase of one (1) or more life insurance policies, inclusive of commissions and fees; and

(6) The failure to provide the disclosures or rights described in this section shall be deemed an unfair trade practice pursuant to § 23-81-817.

History. Acts 2009, No. 796, § 1.

23-81-810. Disclosure to insurer.

(a)(1) Without limiting the ability of an insurer from assessing the insurability of a policy applicant and determining whether or not to issue the policy and in addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(2) If as described in § 23-81-802(11) the loan provides funds that can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the prohibited practices in § 23-81-813.

(3) If the financing does not violate § 23-81-813 in this manner, the insurance carrier:

(A) May make disclosures, including without limitation to the following, to the applicant and the insured on the application or an amendment to the application to be completed no later than the delivery of the policy:

"If you have entered into a loan arrangement in which the policy is used as collateral and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

1. A change of ownership could lead to a stranger owning an interest in the insured's life;

2. A change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

3. Should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, and/or other

factors may reduce the ability to obtain coverage and/or may result in significantly higher premiums;

4. You should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan."; and

(B) May require certifications, such as the following, from the applicant, the insured, or the applicant and the insured:

(i) "I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy.";

(ii) "My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy."; and

(iii) "The borrower has an insurable interest in the insured."

History. Acts 2009, No. 796, § 1.

23-81-811. General rules.

(a) A provider entering into a life settlement contract with any owner of a policy when the insured is terminally or chronically ill shall first obtain:

(1) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a life settlement contract; and

(2) A document in which the insured consents to the release of his or her medical records to a provider, settlement broker, or insurance producer, and if the policy was issued less than two (2) years from the date of application for a life settlement contract, to the insurance company that issued the policy.

(b)(1) The insurer shall respond to a request for verification of coverage submitted by a provider, settlement broker, or life insurance producer not later than thirty (30) calendar days of the date the request is received.

(2) The request for verification of coverage shall be made on a form approved by the Insurance Commissioner.

(3) The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond.

(4) In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(c) Before or at the time of execution of the life settlement contract, the provider shall obtain a witnessed document in which the owner consents to the life settlement contract and represents that the owner has a full and complete understanding of the life settlement contract, that the owner has a full and complete understanding of the benefits of

the policy, acknowledges that the owner is entering into the life settlement contract freely and voluntarily, and for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(d) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(e) If a settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(f) If a broker performs those verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of § 23-81-809(a).

(g)(1) Within twenty (20) days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract.

(2) [Repealed.]

(h) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this subchapter.

(i)(1) All life settlement contracts entered into in this state shall provide that the owner may rescind the contract on or before fifteen (15) days after the date it is executed by all parties to the life settlement contract.

(2) Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period.

(3) If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(j)(1) Within three (3) business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgement of the transfer by the issuer of the policy.

(2) The trustee or escrow agent shall transfer the proceeds due to the owner within three (3) business days of acknowledgement of the transfer from the insurer.

(k)(1) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the proceeds are tendered to and accepted by the owner.

(2) A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until thirty (30) days after the written notice of the right of rescission has been given.

(l)(1) Any fee paid by a provider, party, individual, or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy.

(2) This section does not prohibit a broker from reducing the broker's fee below this percentage if the broker so chooses.

(m) The broker shall disclose to the owner anything of value paid or given to a broker that relates to a life settlement contract.

(n) At any time prior to or at the time of the application for or issuance of a policy or during a two-year period commencing with the date of issuance of the policy, a person shall not enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur. This prohibition does not apply if the owner certifies to the provider that:

(1)(A) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four (24) months.

(B) The time covered under a group policy shall be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

(2) The owner submits independent evidence to the provider that one (1) or more of the following conditions have been met within the two-year period:

(A) The owner or insured is terminally or chronically ill;

(B) The owner or insured disposes of his or her ownership interests in a closely held corporation pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

(C) The owner's spouse dies;

(D) The owner divorces his or her spouse;

(E) The owner retires from full-time employment;

(F) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(G) A final order, judgment, or decree is entered by a court of competent jurisdiction on the application of a creditor of the owner adjudicating the owner bankrupt or insolvent or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

(3)(A) Copies of the independent evidence required by subdivision (n)(2) of this section shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage.

(B) The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider.

(C) This section does not prohibit an insurer from exercising its right to contest the validity of any policy.

(4) If the provider submits to the insurer a copy of independent evidence provided in subdivision (n)(2)(A) of this section when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this section.

History. Acts 2009, No. 796, § 1; 2013, No. 355, § 14.

Amendments. The 2013 amendment repealed (g)(2).

23-81-812. Authority to promulgate rules — Conflict of laws.

(a) The Insurance Commissioner may promulgate rules implementing this subchapter regulating the activities and relationships of providers, brokers, insurers, and their agents, subject to statutory limitations on administrative rulemaking.

(b) Conflict of Laws.

(1)(A) If there is more than one (1) owner on a single policy and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one (1) owner agreed upon in writing by all of the owners.

(B) The law of the state of the insured shall govern if equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(2)(A) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence.

(B) If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering.

(C) For transactions in those states, however, the provider shall maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the State Insurance Department.

(3) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws.

History. Acts 2009, No. 796, § 1.

23-81-813. Prohibited practices.

(a) It is unlawful for any person to:

(1) Enter into a life settlement contract if the person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for the policy;

(2) Engage in any transaction, practice, or course of business if the person knows or reasonably should have known that the intent was to avoid the notice requirements of this section;

(3) Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(4) Issue, solicit, market, or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;

(5)(A) Enter into a premium finance agreement with any person or agency or any person affiliated with the person or agency pursuant to which the person shall receive any proceeds, fees, or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to the policy that are in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of the agreement.

(B) Any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of the overpayment;

(6) With respect to any settlement contract or insurance policy and a broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with the broker;

(7) With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner, if in connection with the life settlement contract, anything of value will be paid to a broker that is controlling, controlled by, or under common control with the provider or the financing entity or related provider trust that is involved in the settlement contract;

(8)(A) With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the Insurance Commissioner.

(B) Marketing materials shall not expressly reference that the insurance is free for any period of time.

(C) The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time is a violation of this subchapter; or

(9) With respect to any life insurance producer, insurance company, broker, or provider, make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(b) A violation of this section is a fraudulent life settlement act.

History. Acts 2009, No. 796, § 1.

23-81-814. Fraud prevention and control.

(a) Fraudulent Life Settlement Act, Interference, and Participation of Convicted Felons Prohibited.

(1) A person shall not commit a fraudulent life settlement act.

(2) A person shall not knowingly and intentionally interfere with the enforcement of this subchapter or investigations of suspected or actual violations of this subchapter.

(3) A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(b) Fraud Warning Required.

(1) Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

(2) The lack of a statement as required in subdivision (b)(1) of this section does not constitute a defense in any prosecution for a fraudulent life settlement act.

(c) Mandatory Reporting of Fraudulent Life Settlement Act.

(1) Any person engaged in the business of life settlements having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide to the Insurance Commissioner the information required by and in a manner prescribed by the commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide to the commissioner the information required by and in a manner prescribed by the commissioner.

(d) Immunity from Liability.

(1) Civil liability shall not be imposed on and a cause of action shall not arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts or suspected or

completed fraudulent insurance acts if the information is provided to or received from:

(A) The commissioner or the commissioner's employees, agents, or representatives;

(B) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(C) A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

(D) Any regulatory body or its employees, agents, or representatives overseeing life insurance, life settlements, securities, or investment fraud;

(E) The life insurer that issued the life insurance policy covering the life of the insured; or

(F) The licensee and any agents, employees, or representatives of the licensee.

(2)(A) Subdivision (d)(1) of this section does not apply to statements made with actual malice.

(B) In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subdivision (d)(1) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

(3)(A) A person identified in subdivision (d)(1) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this subchapter and the party bringing the action was not substantially justified in doing so.

(B) For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subdivision (d)(1) of this section.

(e) Confidentiality.

(1) The documents and evidence provided pursuant to subsection (d) of this section or obtained by the commissioner in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Subdivision (e)(1) of this section does not prohibit release by the commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

(A) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(B) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and

preventing fraudulent life settlement acts, or to the National Association of Insurance Commissioners; or

(C) At the discretion of the commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(3) Release of documents and evidence under subdivision (e)(2) of this section does not abrogate or modify the privilege granted in subdivision (e)(1) of this section.

(f) Other Law Enforcement or Regulatory Authority.

This subchapter does not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued under a state securities law;

(3) Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the State Insurance Department; or

(4) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(g) Life Settlement Antifraud Initiatives.

(1) Providers and brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. At the discretion of the commissioner, the commissioner may order or a licensee may request and the commissioner may grant such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives shall include:

(A) Fraud investigators who may be provider or broker employees or independent contractors; and

(B)(i) An antifraud plan that shall be submitted to the commissioner.

(ii) The antifraud plan shall include without limitation:

(a) A description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent life settlement acts to the commissioner;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and

investigating unresolved material inconsistencies between medical records and insurance applications.

(2) Antifraud plans submitted to the commissioner shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action.

History. Acts 2009, No. 796, § 1.

23-81-815. Injunctions — Civil remedies — Cease and desist.

(a) In addition to the penalties and other enforcement provisions of this subchapter, if any person violates this subchapter or any rule implementing this subchapter, the Insurance Commissioner may seek an injunction in a court of competent jurisdiction in the county where the person resides or has a principal place of business and may apply for temporary and permanent orders that the commissioner determines necessary to restrain the person from further committing the violation.

(b) Any person damaged by the acts of another person in violation of this subchapter or any rule implementing this subchapter may bring a civil action for damages in a court of competent jurisdiction against the person committing the violation.

(c) The commissioner may issue a cease and desist order upon a person who violates any provision of this section, any rule or order adopted by the commissioner, or any written agreement entered into with the commissioner, in accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(d)(1) When the commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, he or she may issue an emergency cease and desist order reciting with particularity the facts underlying such findings.

(2) The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety (90) days. If the State Insurance Department begins nonemergency cease and desist proceedings under subsection (a) of this section, the emergency cease and desist order remains effective, absent an order by an appellate court of competent jurisdiction pursuant to the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(3) In the event of a willful violation of this subchapter, the trial court may award statutory damages in addition to actual damages in an additional amount up to three (3) times the actual damage award.

(4) The provisions of this subchapter shall not be waived by agreement.

(5) A choice of law provision shall not be utilized to prevent the application of this subchapter to any settlement in which a party to the settlement is a resident of this state.

History. Acts 2009, No. 796, § 1.

23-81-816. Penalties.

(a) It is a violation of this subchapter for any person, provider, broker, or any other party related to the business of life settlements to commit a fraudulent life settlement act.

(b) For criminal liability purposes, a person that commits a fraudulent life settlement act is guilty of committing insurance fraud and shall be subject to the penalty provisions under § 23-66-512.

History. Acts 2009, No. 796, § 1.

23-81-817. Unfair trade practices.

A violation of §§ 23-81-801 — 23-81-816 shall be considered an unfair trade practice pursuant to § 23-66-206 and shall be subject to the provisions related to hearings and penalties for violations of §§ 23-66-207 — 23-66-212 of the Trade Practices Act, § 23-66-201 et seq.

History. Acts 2009, No. 796, § 1.

23-81-818. Effective date.

(a)(1) A provider lawfully transacting business in this state before the effective date of this subchapter may continue to do so pending approval or disapproval of that person's application for a license if the application is filed with the Insurance Commissioner not later than thirty (30) days after publication by the commissioner of an application form and instructions for licensure of providers.

(2) If the publication of the application form and instructions is before July 31, 2009, then the filing of the application shall not be later than thirty (30) days after July 31, 2009.

(3) During the time that the application form and instructions are pending with the commissioner, the applicant may use any form of life settlement contract that has been filed with the commissioner pending approval of the application form and instructions, provided the form and instructions are otherwise in compliance with the provisions of this subchapter.

(4) Any person transacting business in this state under this subsection shall comply with all other requirements of this subchapter.

(b)(1) A person who has lawfully negotiated life settlement contracts between any owner residing in this state and one (1) or more providers for at least one (1) year immediately before the effective date of this subchapter may continue to do so pending approval or disapproval of that person's application for a license if the application is filed with the commissioner not later than thirty (30) days after publication by the commissioner of an application form and instructions for licensure of brokers.

(2) If the publication of the application form and instructions is before July 31, 2009, then the filing of the application shall not be later than thirty (30) days after July 31, 2009.

(3) Any person transacting business in this state under this subsection shall comply with all other requirements of this subchapter.

History. Acts 2009, No. 796, § 1.

CHAPTER 83

GROUP LIFE INSURANCE AND ANNUITIES

23-83-110. Grace period for payment of premium provision.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Annual Survey of Caselaw, Insurance Law, 26 U. Ark. Little Rock L. Rev. 931.

23-83-123. Group insurance on Arkansas residents placed in authorized insurers.

(a) All group life, annuity, and accident and health insurance placed by an employer on employees who are residents of this state shall be placed by the employer with an insurer authorized to transact insurance in this state.

(b) This section shall not apply to group insurance lawfully placed in an authorized insurer as a surplus line under § 23-65-101 et seq.

History. Acts 1981, No. 898, § 23; A.S.A. 1947, § 66-3523; Acts 2007, No. 496, § 16.

23-83-124. Group insurance in unauthorized insurer.

(a) Any employer in this state withholding or collecting any money from employees who are residents of this state for any group life, annuity, or accident and health insurance placed with an unauthorized insurer in violation of § 23-83-123 shall be deemed to be the agent of the insurer for the purpose of service of process in any action brought by any employee on the insurance contract.

(b) If the employee is unable to collect a judgment entered in an action against the unauthorized insurer, then the employer referred to in subsection (a) of this section shall be liable for the judgment.

(c) An unauthorized insurer shall be deemed to be doing business in this state for the purpose of service of process in any action.

(d) This section shall not apply to group insurance lawfully placed in an insurer as a surplus line under § 23-65-101 et seq.

History. Acts 1981, No. 898, § 24; A.S.A. 1947, § 66-3524; Acts 2001, No. 1382, § 14; 2007, No. 496, § 17.

CHAPTER 84

STANDARD VALUATION LAW FOR LIFE INSURANCE AND ANNUITIES

SECTION.

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-84-103. Minimum standard for valuation generally.

(a) Except as otherwise provided in §§ 23-84-104 and 23-84-105, the minimum standard for the valuation of all policies and contracts issued prior to the operative date of § 23-81-213(a) shall be provided by the laws in effect immediately prior to January 1, 1960.

(b) Except as otherwise provided in §§ 23-84-104 and 23-84-105, the minimum standard for the valuation of all policies and contracts issued on or after the operative date of § 23-81-213(a) shall be the Insurance Commissioner's reserve valuation methods defined in §§ 23-84-106, 23-84-107, and 23-84-110, three and one-half percent (3.5%) interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, five and one-half percent (5.5%) interest for single premium life insurance policies and four and one-half percent (4.5%) interest for all other policies issued on and after March 18, 1977, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies:

(A) The commissioner's 1941 Standard Ordinary Mortality Table for policies issued prior to the operative date of § 23-81-213(b);

(B)(i) For policies issued on or after the operative date of § 23-81-213(b) and prior to the operative date of § 23-81-213(d), the commissioner's 1958 Standard Ordinary Mortality Table.

(ii) For any category of policies issued on female risks under this subdivision (b)(1)(B), all modified net premiums and present values referred to in this chapter may be calculated according to an age not more than six (6) years younger than the actual age of the insured; or

(C) For policies issued on or after the operative date of § 23-81-213(d):

(i) The commissioner's 1980 Standard Ordinary Mortality Table;

(ii) At the election of the insurer, for any one (1) or more specified plans of life insurance, the commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(iii) Any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the commissioner for the use in determining the minimum standard of valuation for the policies;

(2) For all industrial life insurance policies issued on the standard basis excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table for policies issued prior to the operative date of § 23-81-213(c) and, for policies issued on or after the operative date, the commissioner's 1961 Standard Industrial Mortality Table, or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulations promulgated by the commissioner for use in determining the minimum standard of valuation for the policies;

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the 1937 Standard Annuity Mortality Table, or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner;

(4) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the Group Annuity Mortality Table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners that are approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables, or, at the option of the insurer, the Class (3)

Disability Table (1926) and, for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any table, for active lives, shall be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(6) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for the policies and, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table, or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table and, for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(7) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the commissioner.

History. Acts 1959, No. 148, § 92; 1961, No. 466, § 1; 1965, No. 439, § 1; 1977, No. 551, § 2; 1981, No. 535, § 1; A.S.A. 1947, § 66-2511; Acts 2005, No. 506, § 44.

CHAPTER 85

ACCIDENT AND HEALTH INSURANCE

SECTION.

23-85-137. In vitro fertilization coverage required.

(a) All accident and health insurance companies doing business in this state shall include, as a covered expense, in vitro fertilization.

(b) Pursuant to the applicable provisions of the Arkansas Insurance Code, the Insurance Commissioner may suspend or revoke the certificate of authority of any insurance company failing to comply with the provisions of this section.

(c) After conducting appropriate studies and public hearings, the commissioner shall establish minimum and maximum levels of coverage to be provided by the accident and health insurance companies.

(d) Coverage required under this section shall include services and procedures performed at a medical facility licensed or certified by the Department of Health or another state health department that conform to the guidelines and minimum standards of the:

(1) American College of Obstetricians and Gynecologists for in vitro fertilization clinics; or

(2) American Society for Reproductive Medicine for programs of in vitro fertilization.

(e) Continued certification shall require that the facility is achieving a reasonable success rate with both fertilization and births.

(f) Appropriate laboratory facilities must be provided by the entity requesting certification.

History. Acts 1987, No. 779, § 1; 1991, No. 920, § 1; 2001, No. 909, § 12; 2011, No. 1119, § 1.

Amendments. The 2011 amendment rewrote (d).

CHAPTER 86

GROUP AND BLANKET ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER.

Subchapter 1 — General Provisions

SECTION.

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-86-106. Group accident and health insurance — Definition.

Group accident and health insurance is declared to be that form of accident and health insurance covering groups of persons as defined in

this section, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families or one (1) or more dependents of the groups of persons, and issued upon the following basis:

(1)(A) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of the employer for the benefit of persons other than the employer.

(B) The term "employees" as used in this subdivision (1) shall be deemed to include the:

(i) Officers, managers, and employees of the employer;

(ii) Individual proprietor or partner, if the employer is an individual proprietor or partnership;

(iii) Officers, managers, and employees of subsidiary or affiliated corporations; and

(iv) Individual proprietors, partners, and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(C) The term "employees" as used in this subdivision (1):

(i) May include retired employees; and

(ii) Shall include members of limited liability corporations and members of limited liability partnerships.

(D) A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(E) The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with the trusteeship;

(2)(A) Under a policy issued to an association, including a labor union, when the Insurance Commissioner finds that regardless of where the association is domiciled or does business, the association has:

(i) Articles of incorporation and bylaws;

(ii) At least one hundred (100) members; and

(iii) Been organized and maintained in good faith in active existence for at least two (2) years for purposes other than that of obtaining insurance or insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(B) The term "employees" as used in this subdivision (2) may include retired employees.

(C)(i) Before issuing a group accident and health insurance policy to an association, the association or its insurer on behalf of the association shall file with the commissioner proof that the association meets the requirements of subdivision (2)(A) of this section.

(ii) The commissioner shall approve or disapprove the association as an eligible group policyholder and maintain a list of approved associations.

(iii) An insurer has satisfied the requirements of subdivision (2)(A) of this section if before July 31, 2009, the insurer has:

(a) Filed its association plan or plans with the commissioner; and

(b) Received the commissioner's approval of its forms.

(D) The commissioner may:

(i) Require a previously approved association to provide proof that the association meets the requirements of subdivision (2)(A) of this section; and

(ii) Revoke the authority of a previously approved association to operate as an eligible group policyholder.

(E) An insurer may not issue a group accident and health insurance policy to an association in which the insurer has an affiliation, including without limitation, common:

(i) Board members, officers, executives, or employees;

(ii) Ownership or control of the insurer and the association; or

(iii) Use of office space or equipment utilized by the insurer to transact the business of insurance;

(3)(A) Under a policy issued to the trustees of a fund established by two (2) or more employers in the same or related industry or by one (1) or more labor unions or by one (1) or more employers and one (1) or more labor unions or by an association as defined in subdivision (2) of this section, who shall be deemed the policyholder, to insure employees of the employers or members of the unions or of the association, or employees of members of the association, for the benefit of persons other than the employers or the unions or the association.

(B) The term "employees" as used in this subdivision (3) may include:

(i) The officers, managers, and employees of the employer and the individual proprietor or partners, if the employer is an individual proprietor or partnership; and

(ii) Retired employees.

(C) The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any classes of individuals that could be insured under the group life policy; and

(5) Under a policy issued to cover any other substantially similar group that, in the discretion of the commissioner, may be subject to the issuance of a group accident and health policy or contract.

History. Acts 1959, No. 148, § 419; 1972 (1st Ex. Sess.), No. 49, § 1; A.S.A. 1947, § 66-3701; Acts 2001, No. 1063, § 6; 2001, No. 1604, § 124[125]; 2005, No. 506, § 45; 2009, No. 536, § 1.

Amendments. The 2009 amendment, in (2), inserted (2)(A)(i), (2)(A)(ii), and (2)(C) and made related and minor stylistic changes.

23-86-110. Group accident and health insurance — Administration of benefits.

(a)(1) All group accident and health carriers including hospital and medical service corporations shall be subject to the "primary" and "secondary" carrier rules and regulations promulgated by the Insurance Commissioner.

(2) The secondary carrier shall administer benefits on a timely basis.

(b) This section applies to group contracts of accident and health insurance sold, delivered, or issued for delivery, renewed, or offered for sale in this state.

History. Acts 1975, No. 900, §§ 2, 3; 1981, No. 702, § 2; A.S.A. 1947, §§ 66-3710, 66-3711; Acts 2001, No. 1063, § 10; 2011, No. 760, § 15.

Amendments. The 2011 amendment deleted "including those issued by hospital and medical service corporations, except group contracts for employees whose employer pays one hundred percent (100%) of the premiums" at the end of (b).

23-86-113. Minimum benefits for mental illness in group accident and health policies or subscriber's contracts.

(a) Unless refused in writing, every group accident and health policy or group contract of hospital and medical service corporations issued or renewed after July 1, 1983, providing hospitalization or medical benefits to Arkansas residents for conditions arising from mental illness shall provide the following minimum benefits on and after July 1, 1983:

(1) In the case of benefits based upon confinement as an inpatient in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Behavioral Health Services, the benefits shall be as defined in subsection (b) of this section;

(2)(A) In the case of benefits provided for partial hospitalization in a hospital, psychiatric hospital, or outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Behavioral Health Services as defined in subsection (b) of this section.

(B) For the purpose of this section, "partial hospitalization" means continuous treatment for at least four (4) hours, but not more than sixteen (16) hours in any twenty-four-hour period; and

(3) In the case of outpatient benefits, the benefits shall cover services furnished by:

(A) A hospital, a psychiatric hospital, or an outpatient psychiatric center licensed by the Department of Health;

(B) A physician licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.;

(C) A psychologist licensed under § 17-97-201 et seq.; or

(D) A community mental health center or other mental health clinic certified by the Division of Behavioral Health Services to furnish mental health services as defined in subsection (b) of this section.

(b) The insurer or hospital and medical service corporation may establish a copayment requirement for mental illness benefits paid for inpatient, partial hospitalization, or outpatient care described in subsection (a) of this section, which may or may not differ from the copayment requirements for any other condition or illness, except that copayment requirements for mental illness shall not exceed a twenty percent (20%) copayment requirement.

(c)(1) For accident and health insurance sold to employers of fifty (50) or fewer employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum benefit payable, which shall not be less than seven thousand five hundred dollars ($7,500) per calendar year.

(2) For accident and health insurance sold to employers of fifty-one (51) or more employees, the insurer or hospital and medical service corporation shall not impose limits on benefits under subsection (a) of this section with regard to deductible amounts, lifetime maximum payments, payments per outpatient visit, or payments per day of partial hospitalization which differ from benefits for any other condition or illness, provided that the insurer or hospital and medical service corporation may impose an annual maximum of eight (8) inpatient or partial hospitalization days together with forty (40) outpatient visits.

(d) No person shall disclose mental health history, diagnosis, or treatment services information received in an initial application for coverage or subsequent claims for benefits to any person, group, organization, or governmental agency without written consent of the insured, except for purposes of:

(1) Obtaining professional review and judgments of quality and appropriateness of treatment rendered;

(2) Litigation proceedings involving the insured and when ordered by a court;

(3) Reinsurance, when required;

(4) Applying over-insurance provisions or for purposes of claiming benefits for services on behalf of the insured; or

(5) Underwriting applications for insurance coverage.

(e) Nothing in this section shall be construed to prohibit an insurer, hospital and medical service corporations, a health care plan, health maintenance organization, or other person providing accident and health insurance or medical benefits to Arkansas residents from issuing or continuing to issue an accident and health insurance benefit plan, policy, or contract that provides benefits greater than the minimum benefits required to be made available under this section or from issuing any plans, policies, or contracts that provide benefits that are generally more favorable to the insured than those required to be made available under this section.

(f) The requirements of this section with respect to a group or blanket accident and health insurance benefit plan, policy, or subscriber contract shall be satisfied, if the coverage specified is made available to the master policyholder of the plan, policy, or contract.

(g)(1)(A) Every insurer or hospital and medical service corporation that issues a group accident and health insurance policy, contract, or agreement in this state that provides for mental health coverage shall offer coverage for the payment of services rendered by licensed professional counselors.

(B) The offer shall be made either at the time of application for, or upon the first renewal of, the policy, contract, or agreement after April 1, 1995.

(C) If the offer is accepted, the amount paid for services provided by licensed professional counselors shall be subject to the same limitations as set forth in the policy for mental health coverage.

(2) Nothing in this subsection shall be deemed to expand the scope of the practice of licensed professional counselors currently licensed by the Arkansas Board of Examiners in Counseling and possessing the qualifications set forth in § 17-27-301 et seq., or other applicable laws.

History. Acts 1983, No. 326, §§ 1-5; 1985, No. 236, § 1; A.S.A. 1947, §§ 66-3716 — 66-3720; Acts 1995, No. 1272, § 21; 2001, No. 1063, § 13; 2013, No. 980, § 17.

Amendments. The 2013 amendment substituted "Behavioral" for "Mental" throughout (a).

23-86-119. Disclosure to policyholders.

(a) Upon request from a policyholder with more than twenty-five (25) insured employees under a comprehensive health insurance policy, any insurer issuing or delivering group accident and health insurance policies in this state shall provide to the policyholder the following information for the most recent twelve-month period or for the entire period of coverage, whichever is shorter:

(1) Claims incurred by month;

(2) Premiums paid by month;

(3) Number of insureds to include dependents by month; and

(4) Claims exceeding ten thousand dollars ($10,000) on any individual with diagnosis during the same period.

(b) This section does not require the insurer to disclose any information that is required by law to be confidential.

History. Acts 1999, No. 1002, § 1; 2001, No. 1063, § 19; 2007, No. 496, § 18.

23-86-121. Coverage for anesthesia and hospitalization for dental procedures.

(a) As used in this section, "health benefit plan" means any policy, contract, or agreement offered by an insurance company, health main-

tenance organization, or hospital and medical services corporation to provide, reimburse, or pay for health care services, but does not include the following:

(1) Workers' compensation coverage;

(2) Self-funded or self-insured health plans, unless the plan is established or maintained for employees of a governmental or church entity;

(3) Health plans covering specific diseases other than dental plans;

(4) Hospital indemnity insurance;

(5) Long-term care insurance;

(6) Short-term limited duration insurance;

(7) Accident only insurance;

(8) Medicare supplement insurance; or

(9) Other supplemental insurance.

(b) Health benefit plans shall provide coverage for payment of anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:

(1) The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and

(2) The patient is:

(A) A child under seven (7) years of age who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act, § 17-82-101 et seq., to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;

(B) A person with a diagnosed serious mental or physical condition; or

(C) A person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq.

(c) The health benefit plan may apply deductibles, coinsurance, network requirements, medical necessity determinations, and other limitations as are applied to other covered services.

(d) The health benefit plan may require prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered medical conditions.

(e) If a person is covered under both a health benefit plan that provides dental benefits and a health benefit plan that provides medical benefits, the health benefit plan that includes dental benefits is the primary payer and the health benefit plan that provides medical benefits is the secondary payer, subject to subsections (h) and (i) of this section.

(f) This section does not apply to treatment rendered for temporomandibular joint disorders.

(g)(1) This section applies to health benefit plans that are issued, renewed, extended, or modified on and after January 1, 2006.

(2) "Renewed, extended, or modified" includes a change in premium or other financial term.

(h) This section does not require a health benefit plan that does not cover dental benefits to cover dental care for which general anesthesia or hospital or ambulatory surgical facility services, or both, are performed in connection with dental procedures.

(i) This section does not require a health benefit plan that does not cover charges for hospital or ambulatory surgical facilities generally to cover charges for hospital or ambulatory surgical facilities in connection with dental procedures described in subsection (b) of this section.

History. Acts 2005, No. 439, § 1; 2005, No. 2221, §§ 1, 2.

23-86-122. Prior approval process for experimental and investigational surgical products and medical devices.

(a)(1) "Health carrier" means a health maintenance organization, hospital medical service corporation, or a disability insurance company.

(2) "Health carrier" includes a self-insured governmental or church plan and third-party administrators that administer or adjust disability benefits for a disability insurer, hospital medical service corporation, health maintenance organization, self-insured governmental plan, or self-insured church plan.

(3) "Health carrier" does not include:

(A) An automobile insurer paying medical or hospital benefits under § 23-89-202(1) or a self-insured employer health benefits plan; or

(B) A person, company, or organization licensed or registered to issue or that issues any insurance policy or insurance contract in this state as described in §§ 23-62-102 and 23-62-104 — 23-62-107 providing medical or hospital benefits for accidental injury or disability.

(b) A health carrier that excludes or denies coverage for a specific surgical product or medical device approved for marketing by the United States Food and Drug Administration as experimental or investigational, or both, shall develop a process by which a surgeon, before utilizing the device or treatment, may present medical evidence to obtain a review for the individual patient for coverage of the surgical product or medical device.

History. Acts 2013, No. 464, § 1.

Subchapter 2 — Small-Employer Health Insurance

SECTION.

23-86-202. Definitions.

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individuals acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of § 23-86-204 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans;

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(3) "Carrier" means health insurance issuer, i.e., an insurance company, insurance service, or insurance organization, including a health maintenance organization that is licensed to engage in the business of insurance in a state and that is subject to Arkansas law that regulates insurance, but the term does not include a group health plan;

(4)(A) "Case characteristics" means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, that are considered by the carrier in the determination of premium rates for the small employer.

(B) Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this subchapter;

(5)(A) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

(B) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(i) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for the small employer carrier;

(ii) Have been acquired from another small employer carrier as a distinct grouping of plans;

(iii) Are provided through an association with membership of not less than two (2) or more small employers that has been formed for purposes other than obtaining insurance; or

(iv) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in § 23-86-204(a)(1)(A).

(C) A small employer carrier may establish no more than two (2) additional groupings under each of subdivisions (5)(B)(i), (ii), (iii), and (iv) of this section on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs.

(D) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such an action would enhance the efficiency and fairness of the small employer insurance marketplace;

(6) "Commissioner" means the Insurance Commissioner;

(7) "Department" means the State Insurance Department;

(8)(A) "Health benefit plan" or "plan" means health insurance coverage, i.e., benefits consisting of medical care, provided directly through insurance or reimbursement or otherwise, and including items and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) "Health benefit plan" does not include:

(i) Accident-only, credit, dental, or disability income insurance;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Workers' compensation or similar insurance; or

(iv) Automobile medical-payment insurance;

(9) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(10) "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(11) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

(12)(A) "Small employer" means any person, firm, corporation, partnership, or association actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding year, employed no fewer than two (2) nor more than twenty-five (25) eligible employees, the majority of whom were employed within this state.

(B) In determining the number of eligible employees under subdivision (12)(A) of this section, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered to be one (1) employer; and

(13) "Small employer carrier" means health insurance issuer as defined in subdivision (3) of this section.

History. Acts 1991, No. 1143, § 2; 1997, No. 1000, § 19; 2001, No. 1063, § 21; 2009, No. 726, § 45.

Amendments. The 2009 amendment subdivided (12), inserted "the majority of whom were employed within this state" in (12)(A), inserted "under subdivision (12)(A) of this section" in (12(B), and made related and minor stylistic changes.

Subchapter 3 — Arkansas Health Insurance Portability and Accountability Act of 1997

23-86-311. Guaranteed renewability of coverage for employers in the group market.

RESEARCH REFERENCES

U. Ark. Little Rock L. Rev. Survey of Legislation, 2003 Arkansas General Assembly, Insurance Law, Health Coverage, 26 U. Ark. Little Rock L. Rev. 482.

Subchapter 5 — Small Employer Health Insurance Purchasing Group Act of 2001

SECTION.
23-86-502. Definitions.
23-86-504. Health insurance purchasing group health benefits coverage requirements.
23-86-508. Prevention of conflicts of interest.

Effective Dates. Acts 2005, No. 506, § 54: Mar. 2, 2005. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the laws of this state as to insurance regulation and the Governmental Bonding Board, among others, are inadequate for the protection of the public, and the immediate passage of this act is necessary in order to provide for the adequate protection of the public. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-86-502. Definitions.

As used in this subchapter:

(1) "Commissioner" means the Insurance Commissioner;

(2) "Eligible employee" means an employee or individual who is a full-time employee of an eligible employer and is qualified to enroll in a health benefit plan offered through a health insurance purchasing group;

(3) "Eligible employer" means an employer employing no more than one hundred ninety-nine (199) eligible employees;

(4)(A) "Employer", "employee", and "dependent", unless otherwise defined in this section, shall have the meanings applied to the terms with respect to the coverage under the laws of the state relating to the coverage and the issuer.

(B) "Employer" includes a self-employed individual;

(5) "Full time" means employees working at least thirty (30) hours per week for an eligible employer;

(6) "Health benefits plan" means a group plan, group policy, or group contract for health care services, issued or delivered by a health insurance purchasing group health carrier, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., the Public Employee Workers' Compensation Act, § 21-5-601 et seq., and the no-fault medical and hospital benefit requirements under § 23-89-202;

(7) "Health insurer" means an insurer licensed to transact group accident and health insurance in this state;

(8) "Health maintenance organization" means a health maintenance organization as defined in § 23-76-102 that is licensed to transact business in this state as a health maintenance organization under § 23-76-107;

(9) "Health insurance purchasing group" means a health insurance purchasing group meeting the requirements of this subchapter;

(10) "Health insurance purchasing group health carrier" means a health insurer, health maintenance organization, or hospital and medical service organization;

(11) "Hospital and medical service corporation" means a hospital and medical service corporation as defined in § 23-75-101 that is licensed to transact business in this state as a hospital and medical service corporation under § 23-75-107;

(12) "Large group" means a combination of two (2) or more eligible employers belonging to a health insurance purchasing group;

(13) "Member" means an individual enrolled for health benefits coverage in a health insurance purchasing group;

(14) "Purchaser" means an eligible employer that has contracted with a health insurance purchasing group for the purchase of health benefits coverage;

(15)(A)(i) "State-mandated health benefits" means coverages for health care services or benefits required by state law or state regulations requiring the reimbursement or utilization related to a specific health illness, injury, or condition of the covered person or the inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person.

(ii) However, for the purposes of the options provided by this subchapter, state-mandated health benefits that may be excluded, in whole or in part, shall not include any health care services or benefits that were mandated by Acts 1971, No. 34.

(B) "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific health illness, injury, or condition of the insured, including, but not limited to, those related to continuation of benefits in § 23-86-114, or entitlement to a conversion policy under § 23-86-115; and

(16) "Total eligible employees" means five hundred (500) or more eligible employees.

History. Acts 2001, No. 925, § 2; 2005, No. 2159, §§ 1, 2.

23-86-504. Health insurance purchasing group health benefits coverage requirements.

(a)(1) In conjunction with a health insurance purchasing group health carrier, each health insurance purchasing group that offers health benefit plans to small employers as defined by § 23-86-303 shall guarantee the availability of coverage to small employers as required by § 23-86-312(a).

(2) All health benefit plans provided through a health insurance purchasing group shall be offered at rates, including employer's and employees' share, on a policy-specific or product-specific basis that may vary only as permitted under law.

(b) Subject to subsection (c) of this section, a health insurance purchasing group shall not offer a health benefits plan that unfairly discriminates against eligible employees.

(c) Nothing in this subchapter shall be construed as requiring a health insurance purchasing group health carrier to provide coverage outside the service area of the insurer or organization.

(d) Each health insurance purchasing group shall provide a health benefits plan only through contracts with health insurance purchasing group health carriers and shall not assume insurance risk with respect to the coverage.

(e) Except as provided in this subchapter, the health insurance purchasing group may provide a health benefits plan in whole or in part, not subject to state-mandated health benefits, except those required in the Arkansas Health Insurance Portability and Accountability Act of 1997, § 23-86-301 et seq.

(f) The health insurance purchasing group shall offer at least two (2) types of plans including one (1) plan providing a choice of deductibles with state-mandated health benefits.

(g) The health insurance purchasing group may also offer a health benefits plan not subject to state-mandated health benefits that does not contain standard provisions or rights required to be present in a health benefits plan pursuant to law or regulations unrelated to a specific health illness, injury, or condition of the insured, for the provisions as may be determined by rules and regulations of the Insurance Commissioner.

(h)(1) Every health benefits plan offered through a health insurance purchasing group shall:

(A) Be underwritten by a health insurance purchasing group health carrier that:

(i) Is licensed or otherwise regulated under state law;

(ii) Meets all applicable state standards relating to consumer protection, including, but not limited to, state solvency and market conduct; and

(iii) Offers the coverage under a contract with the health insurance purchasing group;

(B) Be approved or otherwise permitted to be offered under law;

(C) Provide full portability of creditable coverage for individuals who remain members of the same health insurance purchasing group, notwithstanding that they change the eligible employer through which they are members; and

(D) Comply with the provisions of the Arkansas Insurance Code in their sales and solicitation of insurance, including, but not limited to, the Trade Practices Act, § 23-66-201 et seq., and the requirements of §§ 23-64-201 and 23-64-102(1) that all insurance must be sold by an agent licensed by the State Insurance Department.

(2)(A) Any agent referenced in subdivision (h)(1)(D) of this section shall be required to obtain at least two (2) hours of continuing education on a health insurance purchasing group or the plans the health insurance purchasing group sponsors each year, or both.

(B) The requirement in subdivision (h)(2)(A) of this section shall be considered as part of the continuing education requirements provided in § 23-64-301 and shall not preempt or conflict with the provision.

(i) A health insurance purchasing group shall be exempt from the requirements of § 23-86-201 et seq.

(j) Nothing in this subchapter shall be construed as precluding a health insurance purchasing group health carrier from offering a health benefits plan through a health insurance purchasing group by establishing premium discounts for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, so long as the programs are agreed to in advance by the health insurance purchasing group and comply with all other provisions of this subchapter and do not discriminate among similarly situated members.

History. Acts 2001, No. 925, § 4; 2003, No. 1358, § 2; 2005, No. 2159, § 3.

23-86-508. Prevention of conflicts of interest.

(a) A member of a board of directors of a health insurance purchasing group shall not serve as an employee or paid consultant to the health insurance purchasing group but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

(b) An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a health insurance purchasing group or as an employee of the health insurance purchasing group if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in an organization from whom the health insurance

purchasing group receives contributions, grants, or other funds, unless the organization has purchased a contract for coverage through the health insurance purchasing group.

(c)(1) An individual who is serving on a board of directors of a health insurance purchasing group as a representative described in subsection (b) of this section shall not be employed by or affiliated with a health insurance purchasing group health carrier.

(2) As used in subdivision (c)(1) of this section, "affiliated" does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance purchasing group health carrier.

History. Acts 2001, No. 925, § 8; 2005, No. 506, § 46.